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DISCUSSION OF ACUTE KNEE INJURIES*

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THE purpose of this paper is to discuss the problem of acute traumatic knee injuries that may occur in combat zones and in the active military or naval field. The paper makes no effort to go into detail in this discussion but to give only a general idea as to the recognition, treatment, after care, and prognosis of these injuries. The problem of traumatic knees is really one of the important factors of medical care in the treatment of military and naval personnel in the field. My idea of this talk is primarily to advise people relatively unacquainted with the problems of these acute injuries.

Classification of traumatic knee injuries

1. Simple traumatic synovitis
2. Internal lateral ligament strain
3. Dislocated internal semilunar cartilage
4. Injury to the cruciate ligament
5. Osteo-chrondritis dessicans
6. Osteo-chondroma of the knee
7. Osgood-Schlatters Disease

Differential diagnosis

1. Simple traumatic synovitis: This condition is probably the most common and least severe of all traumatic injuries of the knee joint. It occurs following simple, and often, major stress and strain on the knee joint, particularly in straining the internal and lateral structure of the knee joint. The increased irritation of the synovia produces an excess of synovial fluid and this is often described as "water on the knee." However, in rather severe twisting injuries of the knee, the synovial fluid becomes mixed with blood due to tearing of blood vessels in the capusle, causing a hemato-synovitis. Sometimes there is frank blood in the joint space. In a simple synovitis the knee is enlarged and swollen, the patella is floating, and a fluid wave may be palpated in the knee joint. Usually with the knee extended, the greatest amount of fluid is in the super-patella pouch. The tenderness is usually generalized due to the increased pressure of the fluid on the entire capusle of the knee joint. There are usually no areas of specific point tenderness. There is usually associated a few degrees limitation of full extension, flexion is limited beyond 90°, and the patient complains of pain over the anterior aspect of the knee joint. There is no abnormal mobility.

2. Internal lateral ligament strain: This is probably the most common injury of the knee joint. The external lateral ligament is rarely injured due to the anatomical structure of the knee joint. The mechanism of injury of the internal lateral ligament is usually a twisting one in which the knee is thrown violently into a valgus position where excessive strain is applied on the internal lateral ligament. The resulting injury may be the partial tearing of the fibers of the ligament or a definite rupture. The latter, of course, is by far the more serious. In diagnosing this condition, there may be an increase of synovial fluid though this is not as great as that found in a simple synovitis. There is usually point tenderness over the internal condyle of the femur, or the internal condyle of the tibia at the attachments of the internal lateral ligaments. There is usually no tenderness over the internal joint space. There is, in the more severe cases, abnormal lateral mobility so that the knee can be placed in a more valgus position than the uninjured knee. The abnormal mobility, when present, can be easily appreciated, and one can imagine how unstable such a knee could be in walking. In less severe internal lateral ligament strains, the abnormal mobility is less easily demonstrated. In these cases, the diagnosis is best made by the areas of local tenderness.

3. Dislocation of the internal semilunar cartilage: In military and naval service we find many dislocated semilunar cartilages that have been incurred in high school days and in participation in athletic events. These conditions are often aggravated in

continued on next page

*Presented at the Medical Meeting at the U. S. Naval Construction Training Center, Davisville, R. I., on December 21, 1944, under the sponsorship of the New England Committee for Wartime Graduate Medical Meetings.

the service following sudden twisting injuries of the knee joint. These new injuries must be accepted as aggravation of the previously existing condition. The diagnosis of dislocated internal semilunar cartilage is not easy. It is based primarily on a history of the injury, the mechanism of the stress and strain in the injury, pain over the internal joint space of the knee accompanied by tenderness in this area, limitation of full extension, and pain over the internal surface of the knee joint on forced extension. In chronic and recurrent injury, there is a history of "locking" of the knee joint accompanied by inability to fully extend the knee without manipulation. Generally speaking, there is usually limitation of extension, pain over the internal aspect of the knee joint on full flexion, and point tenderness over the internal joint space on local pressure. Occasionally a fullness may be seen or palpated over the internal semilunar cartilage.

4. Injury to the cruciate ligament: This condition is found following an extremely severe straining injury to the knee joint. It is accompanied by weakness, pain, and instability. There may be an associated synovitis which may mislead the examining individual. These injuries are serious, the treatment inadequate, and the outcome bad. A diagnosis is made by abnormal mobility in an anterior-posterior plane. The knee should be extended and anterior-posterior mobility tested. Then the knee should be flexed to 90° and a normal mobility in the anterior-posterior plance be ascertained. If in either of these two positions, the knee is less stable than the opposite one, it is fair to assume that the crucial ligaments have been torn. In any case of the knee injury, the above mentioned procedure should be carried through in attempting to make a diagnosis.

5. Osteo-chrondritis dessicans: This condition is found primarily in individuals of juvenile ages, and with the lower age groups of the Army and Navy should be considered in a discussion of traumatic knee injuries. This condition is primarily associated with youth in a circulatory disturbance of the cartilaginous structures of the joint. It is accompanied by pain, dull aching in character, and also described by weakness, instability, and, occasionally, locking of the knee. It is sometimes accompanied by synovitis but usually the knee is not swollen. The condition is only accurately diagnosed by X-ray. It may pre-exist in injury, be aggravated by an injury, or may occur gradually without any known or recognized traumatic background.

6. Osteo-chrondroma: This condition is usually associated with a circulatory disturbance involving the cartildaginous positions of the knee joint which become separated and free and are described as "joint mice." These may be the aftermath of pieces of cartilage which have separated from the articular surfaces, become loose bodies and later calcify. They may often follow acute hemato-synovitis of the knee joint in which the residual solid particles of the red blood cells have formed a nucleus upon which calcium has been deposited. These "joint mice" become floating bodies in the synovial fluid. They may cause mechanical obstruction between the condyles of the tibis and femur, causing a locking of the joint, instability on walking, a sensation of the knee "giving away," associated with a dull ache and occasional sharp pain. The condition is diagnosed by the history, increased circumference of the knee accompanied by synovitis, the palpitation of the loose fragments of the knee, and by X-ray examination.

7. Osgood-Schlatters Disease: Occasionally in individuals under the age of 19 to 21, there has been a deficiency of circulation in the region of the tibial apophysis. This is primarily a disease of adolescence associated with a primary circulatory deficiency and most often associated with trauma. This is to be considered only in individuals under 21 years of age, as the condition becomes quiescent after the individual reaches his maximum growth and the epiphysis fuses. The condition is recognized by fullness of the tibia tubercle, point tenderness in this area and is substantiated by X-ray examination and evidence of fragmentation of the tibia apophysis. It must be assumed that after approximately age 21 and the epiphysis has been fused, the X-ray evidence of fragmentation may still exist but the condition rarely is activated by trauma. It is fair to say that Osgood-Schlatters Disease becomes stationary after the epiphysis is fused and is not influenced by any trauma except a contusion injury after this time. Very often inexperienced individuals make a diagnosis of fracture of the tibia, when actually the condition seen in the X-ray is a residual fragmentation of the tibia tubercle resulting from a quiescent and stationary Osgood-Schlatters Disease of adolescence.

Treatment

1. Acute traumatic synovitis of the knee: The best treatment for this injury is complete rest of the knee joint. This is best accomplished by complete bed rest and is aggravated by continued activity and work that requires walking and additional stress and strain on the knee. It is understood that in the Armed Forces it is most desirable to keep an individual ambulatory and on limited duty in order to reserve a hospital bed for a person more seriously injured. This can be accomplished by a well-fitting plaster cast of the skin-tight variety that gives complete immobilization of the knee joint. One thing, however, should be remembered: that the cast should not be so low as to cause irritation of the Achilles tendon. This is uncomfortable and unsatisfactory. A plaster cast can be applied from the mid-thigh to the point where

the calf begins to narrow and, if applied snugly, will maintain relatively good immobilization of the knee, diminishing abnormal stress and strain, and allow the individual to walk and bear weight with a stiff knee in a fair amount of security. He should be assigned to limited activity for a period of 3 to 5 weeks depending on the diminuation of the synovitis. These conditions will clear up in 3 to 5 weeks with rest supplemented by heat. There should be no permanent residual after effects.

2. Internal lateral ligament strains: These are more severe than simple synovitis. The minor strains with a minimumal amount of abnormal mobility can be well treated as described above. The more severe cases that have excessive abnormal mobility should be completely immobilized with a plaster cast from toes to the groin. The plaster cast, in my opinion, should be maintained for a period of 6 to 8 weeks. It may be changed during the interim, the abnormal mobility be tested, and a decision made as to how long the cast should be applied. Operative procedures to repair torn internal lateral ligaments are quite unsatisfactory. The results are universally poor. I am of the belief that conservative treatment is the most satisfactory, but it must be understood that permanent damage may have been done and there may be permanent instability of the knee joint. These patients should be hospitalized and immobilized for 6 to 8 weeks followed by physio-therapy and massage. In civilian life, the individual can be immobilized with plaster and made ambulatory with crutches. After 2 weeks, weight bearing on the cast may be allowed or a short plaster as described above may be applied.

3. Dislocated internal semilunar cartilage: When a diagnosis of a dislocated internal semilunar cartilage has been made, the treatment should be governed on the history of the injury. It is my feeling that the first injury and dislocation of an internal semilunar cartilage should be treated conservatively by complete immobilization for 2 or 3 weeks, depending on the symptoms, and lack of weight bearing. If the knee is locked and there is no previous injury, it should be manipulated under anesthesia, reduced, and completely immobilized. If the patient gives a history of recurrent episodes of pain, locking, and instability, the best procedure is excision of the internal semilunar cartilage.

4. Rupture of the cruciate ligaments: When it has been definitely established that the patient has a rupture of either of the cruciate ligaments, the prognosis should be guarded. It is probably best to assume that the patient will always have an unstable knee. The end results, either operatively or conservatively, are universally poor. Operative procedure requires the attempt to re-attach the torn cruciate ligament to its bony foundation. Conservative treatment is employed by the application of a supporting brace to maintain stability of the knee. Both give partial relief. It is my belief that operative procedure is inadequate, and that the operative procedure is not worth the physical risk. If an individual has a ruptured cruciate ligament, I believe that it is best to accept permanent instability and to help maintain what stability is possible by a supporting apparatus.

5. and 6. Osteo-chrondritis dessicans and osteo-chondroma of the knee: As far as these two conditions are concerned, from the Armed Force point of view, these conditions should be considered "existing prior to induction or enlistment." They make the individual incapable of performing full duty status and capable of doing limited duty only or being corrected by operative procedure. The only orthopedic treatment for these conditions is an exploration of the knee joint, removal of the portion of the cartilage that has deficient blood in osteo-chrondritis dessicans, and removal of the loose bodies in osteo-chrondroma.

7. Osgood-Schlatters Disease: This disease, similar to osteo-chrondritis dessicans, is one of the juvenile deficiencies. It usually becomes stationary and quiescent after the age of 21 when the epiphysis have become fused. Before this age, the condition may be activated by direct trauma causing pain, swelling, and weakness of the knee. There are two methods of treatment: The first consists of immobilization of the knee thus allowing the difficulty from the direct blow to subside. This may require two months in an individual who is to be restored to full physical activity. In relatively young individuals with considerable fragmentation of the tibial tubercle, it is often advantageous to make a small incision over the area and make multiple drill holes through the tubercle to increase circulation and bony overgrowth of the apophysis. In either case the symptoms should last from to 2 to 3 months subsequent to the traumatic injury. There is no permanent residual, and, after the age of 21, regardless of treatment, the individual should have no symptoms or discomfort.

Conclusions

This paper has been presented with the hope of giving help to general practitioners who may, in their assignments of duty, be compelled to perform specialized orthopedic procedures and to make specialized decisions as to disposition of injured personnel. We know that a short talk such as this will not serve the purpose of giving complete details as to how these conditions should be treated; but, we hope that the important factors have been brought out so that the question of deferential diagnosis may be clarified. We would suggest that the majority of knee injuries be evacuated to a clearing station for re-assignment rather than an attempt be made to re-establish them in combat zones.

NATUROPATHIC LEGISLATION AND EDUCATION

JOHN E. FARRELL, A.B.

The Author. *John E. Farrell, A.B., Executive Secretary of the Rhode Island Medical Society, and of the Providence Medical Association; Fellow, American Public Health Association.*

SINCE 1939 there have been introduced at five different sessions of the Rhode Island General Assembly measures that would define and regulate the practice of "naturopathy" within this State. The Rhode Island Medical Society, through its Committee on Public Laws, has protested the proposed legislation in each instance, and has sought for hearings at which evidence might be required in support of the need for such measures, and has also requested the presentation of evidence of the educational qualifications of those who would thus be established as doctors and allowed to practice the healing art.

On March 6 of this year the legislation for naturopathy was presented in the House of Representatives of the General Assembly, thus marking the fifth time that such a measure has been introduced. The act, now numbered as House Bill 733, was referred to the House Committee on Judiciary, and the Committee on Public Laws of the Rhode Island Medical Society has again asked for a complete explanation of the proposed act.

When the legislation first appeared in 1939, as Senate Bill 198, the Society sought without success to have a hearing on the proposal. Yet the measure was brought to the floor of the Senate by the Committee on Judiciary with recommendation of passage late in the evening of the final day of the session. On a division vote the act passed and was immediately transferred to the House where it remained in the files upon adjournment of the Assembly.

The following year the measure again was presented, and it became Senate Bill 70. Again, in spite of protests of medical and public health authorities who requested evidence to show the existence of institutions worthy of the approval to be granted, the act, without amendment, was reported out of the Committee on Judiciary with approval on the final session day. It was passed on the basis of this approval and was transferred to the House where it rested in committee files upon the adjournment of the Assembly.

In 1941 the naturopathic legislation was introduced in the House of Representatives by two separate sponsors. As presented, the acts, H-918 and H-930, were identical. They were referred to the Committee on Finance and were not reported out of committee.

After a two year absence the legislation was again introduced in 1944 in the House of Representatives and it became House Bill 784, and it was referred to the Committee on Education. Again the representatives of the State Medical Society made known their views on the proposal, and asked for a complete report on the demand for such legislation, and full evidence of the ability of those who would be qualified under such a law to administer properly any phase of the healing art. These requests were unanswered and the legislation was reported out of the Committee with approval and it was passed by the House after that body had re-convened at 6:45 in the morning after an all-night session which terminated the year's activity. Transferred to the Senate, the measure was left in the files of the Committee on Judiciary when the Assembly adjourned.

In as much as the General Assembly, as the governing body of the State, is instituted for the protection, safety and happiness of the people, and its actions therefore should be made for the good of the whole, the sequence of events related above is of vital concern to every citizen, and not any particular group such as the medical profession or the public health authorities. Unfortunately the public at large has either been indifferent to the seriousness of this problem, or else it has imposed a greater burden upon the State Medical Society than is just and equitable to protect it against treatment by any person or group of persons who would treat physical ailments and disabilities without proper training for such work.

Definitions

Naturopathy is defined by Stedman in his PRACTICAL MEDICAL DICTIONARY as "a system of therapeutics in which neither surgical nor medicinal agents are used, dependence being placed only on natural forces (non-medicinal)". Dorland, in his AMERICAN ILLUSTRATED MEDICAL DICTIONARY, defines it as "a drugless system of therapy by the use of physical forces, such as air, light, water, heat, massage, etc." Thus

it is apparent that at its widest interpretation the term may be applicable to masseurs, or to chiropractors.

However, when it comes to legislative proposals those who seek recognition for licensure in naturopathy expand these definitions to include practically all forms of healing, while at the same time excusing themselves from meeting educational requirements demanded equally of others who pursue the healing art in any of its phases, even to the extent of examinations in the basic sciences.

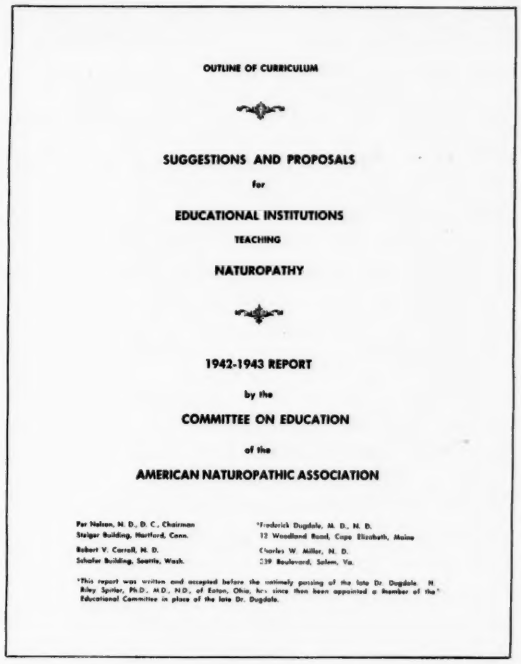
The acts placed before the Rhode Island General Assembly have had in each instance a different definition of what would constitute naturopathy. However, the definition stated in the measure passed by the House in 1944 in which, as in the previous proposals, the practice would include "such other methods of treatment as are taught in the various recognized schools of naturopathy", when compared with the curriculum for naturopathic colleges as recommended by the educational committee of the American Naturopathic Association leaves little doubt as to the extent to which these pretenders in the field of healing art seek to administer to the people of Rhode Island.

Educational Committee and Schools

In advancing their proposal before the Assembly in 1944 the advocates of naturopathy presented for the first time a printed folder giving suggestions and proposals for educational institutions teaching naturopathy, and a recommended outline of curriculum. This leaflet was advanced as the 1942-1943 report by the Committee on Education of the American Naturopathic Association, (Figure 1). Included in the report is a list of educational institutions to whom appreciation is expressed by the Committee for their splendid cooperation, presumably in formulating the outline of curriculum for naturopathic colleges.

The Committee lists as its members a Per Nelson of Hartford, Conn., a Robert Carroll of Seattle, Washington, a Charles Miller of Salem, Virginia, a Frederick Dugdale of Cape Elizabeth, Maine, who died prior to the writing and acceptance of the report and whose place on the Committee was taken by an H. Riley Spitler of Eaton, Ohio. The report itself carries the printed names as signatories of only Nelson, Carroll, and Dugdale. Each of these men is listed as a naturopathic doctor. (Figures 1 and 2).

Although it is the purpose of this study to discuss primarily the educational institutions advancing the cause of naturopaths, some comment must necessarily be made regarding the members of the Educational Committee of the American Naturopathic Association as listed on the report to which reference is made, since they represent the leaders in naturopathic education.



OUTLINE OF CURRICULUM

SUGGESTIONS AND PROPOSALS
for
EDUCATIONAL INSTITUTIONS
TEACHING
NATUROPATHY

1942-1943 REPORT
by the
COMMITTEE ON EDUCATION
of the
AMERICAN NATUROPATHIC ASSOCIATION

Per Nelson, M. D., D. C., Chairman
Steiger Building, Hartford, Conn.

*Frederick Dugdale, M. D., N. D.
12 Woodland Road, Cape Elizabeth, Maine

Robert V. Carroll, N. D.
Schafer Building, Seattle, Wash.

Charles W. Miller, N. D.
539 Boulevard, Salem, Va.

*This report was written and accepted before the untimely passing of the late Dr. Dugdale. H. Riley Spitler, Ph.D., M.D., N.D., of Eaton, Ohio, has since been appointed a member of the Educational Committee in place of the late Dr. Dugdale.

Figure 1

Per Nelson, chiropractor and naturopath, of Hartford, Connecticut, was a graduate in 1916 of Blumer College, in Hartford, a small school which was closed during the diploma mill investigation in 1923. He also lists training at the National College of Chiropractic in Chicago, and a Pennsylvania Orthopedic school in Philadelphia of which no information is available.

Robert V. Carroll, of Seattle, is licensed in the State of Washington as a sanipractic physician, as that State does not recognize naturopathy. Charles W. Miller of Salem, Virginia, a naturopath, was prosecuted and convicted for practicing without a license, and though he appealed the case to the Supreme Court the conviction was upheld. However, in accordance with the medical practice act of that State, as amended by the 1944 assembly, he can now get a temporary license to practice in Virginia but he will have to take an examination to secure a permanent license.

H. Riley Spitler, who succeeded Frederick Dugdale of Maine as a member of the Committee, is a resident of Eaton, Ohio, where naturopathy is not a recognized branch of the healing art. He received certificates to practice chiropractic, spondylotherapy, and neuropathy in 1916, and mechanotherapy in 1925. These applications were made on the basis of years of practice, provided for at the time the Limited Practice Act was enacted in Ohio. This provision exempted men who had been in practice

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for a period of time before enactment of the law to qualify and receive a certificate by passing a practical examination only.

In this age when people in general are more conscious of the importance of maintaining good health, and when medical and scientific research have made such outstanding progress in the prevention of disease, it is imperative that licensure to practice any phase of the healing art have as a prerequisite complete and sound educational training to prepare for the scope of practice to be pursued by the individual healer. Therefore, in view of the all-inclusive grants proposed for themselves by the local advocates of naturopathy it is imperative that a complete report be forthcoming on each institution which would train such practitioners. This limited study of the educational institutions that assisted the national naturopathic committee in its report (Figure 2), and therefore are to be considered as institutions approved by that body, is necessarily brief.

IN CONCLUSION

The personnel of the Committee on Education of the A.N.A. wishes to express its sincere appreciation for the many helpful suggestions offered by individual educators and practitioners of the healing arts—too many to be mentioned by name in this brief report.

We also wish to express our appreciation to the following educational institutions for their splendid cooperation:

The American Physio-Therapy Institute, 2210 North Meridian Street, Indianapolis, Indiana.
The Australian School of Naturopathy, 1608 West Madison Street, Chicago, Illinois.
The Central States College of Physiatrics, Eaton, Ohio.
The Colorado Mineral Health School, Commonwealth Building, Denver, Colorado.
The Columbia College of Naturopathy, 708 East 13th Street, Kansas City, Missouri.
The First National University of Naturopathy, 143 Roseville Avenue, Newark, New Jersey
The Metropolitan College, 3400 Euclid Avenue, Cleveland, Ohio.
The Nashville College of Drugless Therapy, 220 Boscobel Street, Nashville, Tennessee
The National College of Drugless Physicians, 20 North Ashland Boulevard, Chicago, Ill.
The Polytechnic College and Clinic of Natural Therapeutics, 1118 South Calhoun Street, Fort Wayne, Indiana.
The Southern University of Naturopathy and Physio-Medicine, 1321 Southwest Fourth Street, Miami, Florida.
The University of Natural Healing Arts, 1600 Logan Street, Denver, Colorado.
The Western States College, 1536 S. E. Eleventh Avenue, Portland, Oregon.

Respectfully submitted,
The Educational Committee, American Naturopathic Association
Signed { Per Nelson, N. D., D. C., Chairman
Robert V. Carroll, N. D.
Frederick Dugdale, M. D., N. D.

Figure 2

REPORT ON SCHOOLS

THE AMERICAN PHYSIO-THERAPY INSTITUTE
2210 North Meridian Street, Indianapolis, Indiana

The American Physio-Therapy Institute is synonymous with the Indiana Physio-Therapy College, Inc., since both are at the same address and under the same auspices. Legally it is the successor of the Indiana Chiropractic School, incorporated in 1911 under the Voluntary Association Act of 1901. Connected with the school and located at the same address are other organizations promoted by Harry Francis, president of the College. These organizations include the American Health Institute, National Business Service, Inc., Modern Minute Men, Inc., American Federation of Physio-Therapists, affiliate of the American Federation of Labor, National Union Charter No. 21527.

In its two page leaflet giving information showing subjects covered, requirements, costs and general information regarding the various courses, the following reference is made to naturopathy: "When the student has received our Doctor of Physio-Therapy degree we have a Special Course in Naturopathy which covers Bio-Chemistry and Herbal Remedies. This course requires 200 hours of Resident Work and costs $50.00."

An inquiry to the College regarding enrollment for naturopathy courses resulted in the following information from the Registrar:

> **"Since you have had no previous training it would be necessary for you to complete the following course in order to obtain the degree of Doctor of Naturopathy:**
>
> **1. the special foundation course at a cost of $250.00.**
>
> **2. the combined advanced course and Naturopathy course at a cost of $211.00, making a total of $461.00. We enclose two application blanks covering these courses. The cost of text books is included in the above figures, although there are other books we recommend at times that the students purchase.**
>
> **"About fifty per cent of the work may be completed by correspondence at home and we suggest that you enroll immediately at least for the special foundation course and cover your extension work. Then this summer you would be able to attend our resident classes in September.**
>
> **"The courses as outlined above would give you the following degrees: Physio-Therapy Technician; Doctor of Physio-Therapy; and Doctor of Naturopathy . . ."**

The Better Business Bureau of Indianapolis, which has made investigations of this Institute and its affiliated organizations, reports that "because of the nature of courses this school offers, because in general diplomas are issued to anyone who pays the tuition fee, with a negligible amount of schooling, and because we believe this school is primarily a private promotional enterprise of Harry Francis, this Bureau strongly disapproves of the school and Harry Francis."

The correspondence cited above would appear to bear out in no small measure this opinion of the Business Bureau.

THE AUSTRALIAN SCHOOL OF NATUROPATHY
1608 West Madison Street, Chicago, Illinois

No information regarding this school is available through the Illinois Department of Registration and Education. However, a communication addressed to the school late in July, 1944, brought

an answer from a Robert A. Wood, N.D. under whose personal supervision the school operates, that states in part as follows:

> **"We had very fine classes until the war started taking our students, so we decided to finish up with those that were left and close the school until the conflict is over. New inquiries have somewhat changed our minds and if sufficient students can be got together we will not wait until the war is over. At any rate, it will not be long before it is over.**
>
> **"Here are some of the subjects we teach: anatomy, physiology, bacteriology, pathology, organic and inorganic chemistry, massage, mechano-therapy, chiropractic, osteopathy, dietetics, colon irrigation, fasting milk diet, hydro-therapy, system of hot packing, iridiagnosis, treatment of diseases by natural methods, philosophy of natural therapeutics, heat, light, scientific exercise, reducing, etc., and many other interesting subjects.**
>
> **"Illustrated lectures, black board work, home work, etc. makes up our methods of study. It takes fours years at nine months each year to complete the course. The tuition is twenty-five dollars a month. The full tuition is eight hundred dollars. There are a lot of positions available in Chicago. One must have High School in order to take up the study of Naturopathy . . . Thousands of Naturopathic Physicians practicing all over America without a license."**

CENTRAL STATES COLLEGE OF PHYSIATRICS
Eaton, Ohio

A communication to this College in 1944 brought the answer that "due to the war we are not holding classes at the college at the present time. There is a possibility that we may start classes the first of the year."

Dean of this college is the H. Riley Spitler previously referred to as a member of the naturopathic educational committee. Since naturopathy is not recognized in Ohio the Central States College was chartered in 1929 as an institution for the teaching of physiatrics in all its phases. According to its catalog the college under its charter "is empowered to confer the professional degree of Doctor of Mechanotherapy upon students who seek registration to practice in Ohio, or the degree of Doctor of Naturopathy upon students who may seek registration in other states."

Although the catalog goes into detail to explain that physiatrics, according to Webster is "the system, practice, or science of using nature's agencies in healing", yet it also calls specific attention to the fact that "the several practices in the field of physiatrics are known by names, such as "movement cure", "nature cure", "osteopathy", "natural therapeutics", "naturopathy", "mechanotherapy", "chiropractic", "sanipractic", "drugless healing", and many other names. Obviously this multiplicity of names has resulted in considerable confusion in the minds of the general public, and even more so in the minds of members of the several states' legislative bodies. The result is that the practice of physiatrics is styled by one or more of these names in laws regulating its practice."

THE COLORADO MINERAL HEALTH SCHOOL
Denver, Colorado

A communication from this school states "we have closed all school work for the duration". No catalog is available on the courses of study that were offered, but the letterhead cites that the school was established in 1924 by George Collingwood, (naturopath), licensed in Colorado and California, of School of Life Chemistry. The letterhead also calls attention to "teaching bio (life) chemistry, use of cell salts, food science, etc., vibratory diagnosis", and claims "students in every state and some foreign countries", with "personal classes taught" and "in many cities home study course."

COLUMBIA COLLEGE OF NATUROPATHY
708 East 13th Street, Kansas City, Missouri

A letter addressed to this college in June, 1944, was returned to the writer unclaimed, with the postal stamp mark "NOT IN DIRECTORY".

The County Recorder's Office has recorded in Book B-3154, Page 169, the court decision granting the pro forma decree of incorporation on September 26, 1934. The purpose of the organization is for teaching and granting degrees as doctors of naturopathy, and therefore it would appear that the college is a legally instituted school in the State of Missouri provided the charter is still in full force and effect.

Naturopaths are not recognized through medical license in Missouri.

FIRST NATIONAL UNIVERSITY OF NATUROPATHY
143 Roseville Avenue, Newark, New Jersey

A report from the Board of Medical Examiners of the State of New Jersey regarding this school, and its head, a Frederick W. Collins, states in part as follows:

> **". . . Frederick W. Collins of Newark, N. J. is licensed to practice osteopathy and chiropractic in this State but is not licensed to practice medicine and surgery.**
>
> **"Collins has been dean of a number of schools reaching a branch of medicine and surgery, among them, the College of Mecca of Chiropractic, the United States School of Naturopathy, and the First National University of Naturopathy and Allied Sciences.**
>
> **"In 1926 the Board proceeded against the College of Mecca of Chiropractic for conducting a school teaching a branch of medicine and surgery, or a method of treatment of disease or any abnormal condition without first securing from the Board a license as provided for by Title 18, Chapter 20, Artitle 3, of the Revised Statutes of New Jersey. The case was tried . . . and the Judge found the College guilty as charged and a conviction was entered. The College applied to the Supreme Court for a writ of certiorari, which was allowed and the conviction in**

the trial court was sustained by the Supreme Court on June 27, 1928. An appeal was taken to the Court of Errors and Appeals by the defendant and the decision of the Supreme Court was affirmed by the Court of Errors and Appeals in May, 1929.

"In 1932 the College of Mecca of Chiropractic applied to the Supreme Court to review resolution adopted by the Board setting up requirements to be met by schools that apply for a license under the provisions of Title 18, Chapter 20, Article 3 of the Revised Statutes of New Jersey.

"Following decision on this writ Collins changed the name of his College to the First National University of Naturopathy and Allied Sciences. In 1934 we prepared a case against the new College and referred it to the Attorney General for action. However, before the papers could be obtained from the Attorney General and served, Collins discontinued the operation of the College.

"Collins uses the title of M.D., which he is not legally permitted to do, but claims it designates Master Diagnostician."

Prior to the receipt of the above communication a letter addressed to the First National University of Naturopathy and Allied Sciences for information about courses in naturopathy brought a catalog, copyrighted in 1930, but enclosed in an envelope with the outside return address of VIRTUOSO SCHOOL OF MUSIC, 143 Roseville Avenue, Newark, New Jersey. A letter from Dr. Frederick W. Collins at a return address of 47 South 11th Street, Newark 7, N. J. was also received.

In his communication, written on stationery with a letterhead of the First National University of Naturopathy and Allied Sciences, Collins stated:

"Thanks for your letter of June 13. I am putting on Private Post Graduate Courses in Naturopathy as you will see by the enclosed list.

"In the State of N. J. you can practice what we call openly by calling yourself a Physical Culturist. We have a Supreme Court decision that the Doctors are using by which the Medical Doctors cannot molest you legally.

"I think it would be a good plan for you to come down and see me and talk the matter over. I am sending you a copy of our last catalog and other literature."

The enclosed list referred to in this letter is a statement of a private course given by Collins on Tuesday night, the fee for which is $50 if paid in advance, otherwise $5 weekly for twelve weeks. Also incorporated in the list were reputed texts with a total list price of $31.75, but offered for $18 if purchased at one time.

THE METROPOLITAN COLLEGE
3400 Euclid Avenue, Cleveland, Ohio

Communications from this College brought forth the following information:

"Naturopathy is a graduate course given after all other basic work is completed and requires six months additional work. A diploma in Naturopathy from this college will admit you to examination in any state in the Union having a Naturopathic law."

* * * * *

"Classes will continue to be held Monday, Tuesday and Thursday evenings from 6:30 to 10:30 P. M. This is our way of cooperating so that you may engage in essential industry and prepare for the future at the same time . . . The title of Doctor is respected everywhere,—this is your chance to acquire it."

In its catalog the Metropolitan College points out that "naturopathy is a system of the application of natural methods, comprising the use of air, water, earth, sunshine, heat, cold, harmonized foods, exercises (mentally and physically), rest, dehydrated vegetation, herbs and other natural modalities." To supply this training the College states that it offers under its department of naturopathy, phytotherapy, dietetics, electrotherapy, mechanotherapy, hygiene, first aid, sanitation, heliotherapy, and as special subjects — terminology, hygiene, first aid, dietetics, roentgenology, jurisprudence.

THE NASHVILLE COLLEGE OF DRUGLESS THERAPY
220 Boscobel Street, Nashville, Tennessee

According to its literature the Nashville College of Drugless Therapy was started in the fall of 1934, and the Chiropractic College was added about a year later. In 1936 a department of Naturopathy was added.

As a result of this arrangement the College reports that:

"The COMPLETE course of the Nashville College of Drugless Therapy is unique in that this is the ONLY school combining in one great course THREE of the most outstanding and efficient healing methods known to man — CHIROPRACTIC — NATUROPATHY — NEUROPATHY.

"Each student who takes our Complete Course receives THREE degrees — N.D., D.C., D.N. . . . Once you understand their different philosophies, methods, and respective fields, you would never think of practicing without the combination, because you can always have several times as many opportunities to get sick people well and fit your treatment to each patient's personality.

"Naturopathy — Each one finishing our COMPLETE Chiropractic Course is, as stated above, also given thorough training in, and graduated as a Doctor of Naturopathy, and is eligible to license anywhere either as a Chiropractor, Naturopath, or Drugless Physician, or all three . . ."

Commenting on its technique and Methods, the College, in its literature, states "Nashville College has always held that it is morally and professionally wrong for a student to graduate from any school with just one, or maybe two, methods of adjusting or treating the human framework, so we set ourselves to use and teach all forms of adjustive procedure known to the profession. Name your technique, and we believe that we will be able to produce it, or something, maybe under a different name, that does the same work."

As a further inducement to pursue its courses, the College announced post graduate courses "for the doctor, already in the field and practicing, who wishes to pick up the latest and best in such sub-

jects as Tonsil Coagulation, Hemorrhoid Dehydration, Minor Surgery, Gynecology, Obstetrics, Laboratory Diagnosis, Physical Diagnosis, Oxygen Therapy, Fever Therapy, Psyciotherapy, Colonic Irrigations, etc. SPECIAL instruction in these subjects may be arranged at any time. Write us your needs. The price is $25.00 per week for each doctor for regular "run-of-the-mill" instruction, or $50.00 per week for intensive, personalized training."

For the student who does not take the Complete Course which gives the three degrees, including that of doctor of naturopathy, the College announces a post graduate course of "Six months advanced study in Naturopathy which will qualify graduate drugless physicians for the degree, Doctor of Naturopathy, $150.00 cash with enrollment."

THE NATIONAL COLLEGE OF DRUGLESS PHYSICIANS
20 North Ashland Boulevard, Chicago, Illinois

Founded in 1906 and incorporated under the laws of Illinois as the National School of Chiropractic, the school had its name legally changed in 1920 to that of the National College of Chiropractic.

In answer to an inquiry regarding its teaching of naturopathy the College has stated —

> **"We should explain that the National College of Chiropractic, in conjunction with the National College of Drugless Physicians, offers a four-year combined course in chiropractic and naturopathy."**

In its catalog the College states that "this four year course qualifies the student for practice in any and all states having chiropractic laws". And further, "upon completion of this course the degree Doctor of Chiropractic is conferred and the degree of Doctor of Drugless Therapy". Regarding other degrees the catalog states "Students who desire the degree Doctor of Naturopathy can earn this degree by including naturopathic subjects in their course", and "Those who wish to obtain a license to practice Mechano-Therapy in the State of Ohio may qualify for this degree."

It is interesting to note that this College is incorporated as the National College of Chiropractic, and all its literature carries that title. Yet, as noted in the abstract from the communication referred to above, the name National College of Drugless Physicians is spoken of as if a different institution whereas it is but another name, apparently used for convenience, for the National College of Chiropractic.

Utilization of the synonymous title of College of Drugless Physicians to further naturopathy legislation in Rhode Island was employed in advancing the measure placed before the General Assembly in 1941. At that time, to substantiate their claim of a College of Naturopathy, the proponents of the bill submitted a single page flyer, printed on one side, showing a photo of the National College of Chiropractic, but captioned the National College of Drugless Physicians. The page heading bore similar caption, and no mention was made anywhere on the page that the school was properly the National College of Chiropractic. In addition, a summary of a Naturopathic Course for four years was listed, but a perusal of the College catalog fails to show a similar summary. The flyer was further decorated with four photos showing a "classroom at the National College", the "dissection laboratory", the "clinical diagnosis laboratory", and a "section of National College clinic". All four photos were previously published in a pictorial supplement of the National College of Chiropractic to advertise the College.

The impression was given to the Senate Committee to whom the proposed legislation had been referred, that the National College of Drugless Physicians was devoted exclusively to the teaching of naturopathy.

THE POLYTECHNIC COLLEGE AND CLINIC OF NATURAL THERAPEUTICS
1118 South Calhoun Street, Fort Wayne, Indiana

Communications directed to this school were not answered.

The school was incorporated in Indiana, March 3, 1940, "to conduct courses of instruction and to issue diplomas for the practice of chiropractic and naturopathy, physio-therapy, hydro-therapy, and Swedish movement and massages, and all natural therapeutic methods and the study of basic sciences appertaining thereto, and for the maintenance of a clinic thereto."

A Charles J. Costner, one of the founders of the school, was reported in 1944 as located in Tennessee, apparently having abandoned the project in Indiana. However, the American Naturopathic Association of Indiana, Inc., which is closely linked to the operation of the school, filed an annual nonprofit corporation report in January, 1944, which might indicate existence of the school at that time.

Indiana does not recognize Naturopathy and a bill for a separate licensing board for such a group failed of enactment during the 1941 session of the legislature.

THE SOUTHERN UNIVERSITY OF NATUROPATHY AND PHYSIO-MEDICINE
1321 Southwest Fourth Street, Miami, Florida

In its prospectus issued in 1940 the Southern University of Naturopathy and Physio-Medicine states that it "was organized in 1927 and chartered under the laws of the State of Florida on January 7th, 1929, to conduct a University of the healing

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Program . . . 134th Annual Meeting

RHODE ISLAND MEDICAL SOCIETY

May 16-17, 1945 — *At the R. I. Medical Society Library, Providence*

WEDNESDAY, MAY 16

2:00 P.M. CALL TO ORDER

WELCOME BY PRESIDENT, Elihu S. Wing, M.D.

RECOGNITION OF DELEGATES FROM OTHER SOCIETIES

2:15 P.M. "DISCUSSION OF THE CAUSES OF CANCER"

STANLEY P. REIMANN, M.D., of Philadelphia

(Director, Lankenau Hospital Research Institute; Chairman, Cancer Commission, Pennsylvania Medical Society; Associate Professor of Surgical Pathology, Graduate School, Univ. of Pennsylvania; Professor of Oncology, Hahnemann Medical College and Hospital)

S. P. Reimann, M.D.

2:45 P.M. "PSYCHOSOMATIC MEDICINE — A CRITIQUE"

CARL BINGER, M.D., of New York

(Assistant Professor of Clinical Psychiatry, Cornell University Medical School)

Carl Binger, M.D.

3:15 P.M. "TREATMENT OF BACTERIAL ENDOCARDITIS WITH PENICILLIN"

ARTHUR J. GEIGER, M.D., of New Haven

(Associate Physician, New Haven Hospital and Dispensary; Assistant Professor of Medicine, Yale University School of Medicine)

3:35 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

4:10 P.M. "SOME EXPERIENCES WITH THE SURGICAL TREATMENT OF HYPERTENSIVE CARDIOVASCULAR DISEASE"

REGINALD H. SMITHWICK, M.D., of Boston

(Associate Visiting Surgeon, Massachusetts General Hospital; Instructor in Surgery, Harvard Medical School)

4:40 P.M. "GERIATRICS"

ROGER I. LEE, M.D., of Boston

(President-elect, American Medical Association; former president, American College of Physicians and of the Massachusetts Medical Society; former chairman, Board of Trustees, American Medical Association; Member, National Advisory Health Service)

Roger I. Lee, M.D.

5:10 P.M. TOUR OF THE TECHNICAL EXHIBITS

6:00-7:00 P.M. SOCIAL HOUR . . . . . At the Biltmore Hotel
(For Members of the Society and their Guests)

EVENING SESSION

At the Medical Library

Presiding: HALSEY DEWOLF, M.D., of Providence, *Anniversary Chairman*

9:00 P.M. GREETINGS: HON. J. HOWARD MCGRATH
Governor of the State of Rhode Island

REMARKS: ROGER I. LEE, M.D.
President-elect, American Medical Association

The Charles V. Chapin Oration —

Francis G. Blake, M.D.

"SOME RECENT ADVANCES IN THE CONTROL OF INFECTIOUS DISEASES"

FRANCIS G. BLAKE, M.D.
(Dean and Sterling Professor of Medicine, Yale University School of Medicine)

The Charles V. Chapin Memorial Award —
HON. DENNIS J. ROBERTS
Mayor of the City of Providence

THURSDAY, MAY 17

At the R. I. Medical Society Library

10:30 A.M. "NEWER DEVELOPMENTS IN THE ETIOLOGY AND TREATMENT OF DIABETES"

ELLIOTT P. JOSLIN, M.D., of Boston
(Medical Director, George F. Baker Clinic, New England Deaconess Hospital)

11:00 A.M. "THE USE AND ABUSE OF BARBITURATES"

FREDERICK C. IRVING, M.D., of Boston
(William Lambert Richardson Professor of Obstetrics, Harvard Medical School; Visiting Obstetrician, Boston Lying-in Hospital)

Frederick C. Irving, M.D.

continued on next page

11:30 A.M. Round Table Discussion

Samuel A. Levine, M.D.

"CORONARY ARTERY DISEASE"

Introduction and Final Summary by

SAMUEL A. LEVINE, M.D., of Boston

(Physician, Peter Bent Brigham Hospital; Assistant Professor of Medicine, Harvard Medical School)

The Pathology of Coronary Artery Sclerosis and Thrombosis

B. EARL CLARKE, M.D., of Providence

(Pathologist, Rhode Island Hospital; President, Providence Medical Association)

The Neuro-Psychiatric Aspects of Coronary Artery Disease

CARL BINGER, M.D., of New York

(Assistant Professor of Clinical Psychiatry, Cornell University Medical School)

The Clinical Findings of Acute Coronary Thrombosis

ALEX M. BURGESS, M.D., of Providence

(Chief, Medical Service, Rhode Island Hospital; Professor of Health and Hygiene, Dept. of Medical Sciences, Brown University)

The Treatment of Acute Coronary Thrombosis

ARTHUR J. GEIGER, M.D., of New Haven

(Associate Physician, New Haven Hospital and Dispensary; Assistant Professor of Medicine, Yale University School of Medicine)

12:30 P.M. LUNCHEON (A buffet lunch will be available to members of the Society in the basement dining room)

2:00 P.M. "THE CLINICAL APPLICATION OF LABORATORY FACILITIES"

WILLIAM R. OHLER, M.D., of Boston

(Assistant Professor of Medicine, Harvard Medical School, Courses for Graduates)

2:30 P.M. "DERANGEMENTS OF THE KNEE JOINT"

Jacob Gershon-Cohen

From the Viewpoint of the Radiologist:

LT. COMDR. JACOB GERSHON-COHEN, MC, USNR, of Newport, R. I.

(Associate Professor of Radiology, Graduate School, University of Pennsylvania; Chief, Radiological Service, Newport Naval Hospital)

From the Viewpoint of the Orthopedist:

COMDR. EDGAR K. HOUCK, MC, USNR

(Of Newport Naval Hospital and Reading, Pa.)

3:00 P.M. "SURGERY OF THE VEINS OF THE LEG — VARICOSITY AND SOME PROBLEMS IN THROMBOSIS"

JOHN J. HOMANS, M.D., of Boston

(Clinical Professor of Surgery, Harvard Medical School; Professor of Clinical Surgery, Tufts Medical School)

3:30 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

4:00 P.M. "CLINICAL USES OF PENICILLIN"

DONALD C. ANDERSON, M.D., of Boston
(Research Fellow in Medicine, Evans Memorial Hospital; Instructor in Medicine, Boston University School of Medicine)

D. C. Anderson, M.D.

4:30 P.M. "MEDICAL CARE IN RHODE ISLAND"

Elihu S. Wing, M.D.

ELIHU S. WING, M.D., of Providence
(President, Rhode Island Medical Society; Chief, Medical Service, Rhode Island Hospital)

5:00 P.M. INSTALLATION OF OFFICERS for 1945-46

Exhibitors at the

134th ANNUAL MEETING OF THE RHODE ISLAND MEDICAL SOCIETY

Space	*Name*	*Space*	*Name*
1	Winthrop Chemical Company	16	Eli Lilly & Company, Inc.
2	Buffington's, Inc.	17	Philip Morris & Company
3	Blanding & Blanding	18	Davies, Rose & Company, Ltd.
4	Spencer Inc.	19	Smith, Kline & French Laboratories
5 & 6	Burroughs Wellcome & Company	20	Owens-Corning Fiberglas Corporation
7	Nutrition Research Laboratories	21	Alkalol Company
8	Sharp & Dohme, Inc.	22	Lederle Laboratories
9	Mead Johnson & Company	23	Doho Chemical Company
10	Coca-Cola Bottling Company of R. I.	24	Bilhuber-Knoll Corporation
11 & 12	The Claflin Company	25	U. S. Vitamin Corporation
13	Boss & Seiffert Company	26	H. J. Heinz Company
14	White Laboratories	27	Schering Corporation
15	The Borden Company	28	C. V. Mosby Company
Miller Room	Smith-Holden Company		

MEDICAL MEETINGS

The action of the Committee on War Conventions in requesting clearance through it for all assemblies has resulted in the voluntary cancellation of most medical meetings throughout the country. The majority of the State Medical Societies have followed the example set by the national and sectional organizations in order to relieve the burden of additional strain upon the railroads and the hotels, in particular.

We in Rhode Island are most fortunate in this instance. The unselfish action of Roger Williams and his successors in restricting our land space to give us the smallest colony, and ultimately the smallest State in the country, has its counterpart in a compact, unified population which has easy access to every part of "little Rhody" without the dependence on railroad transportation.

The wisdom of the great men of medicine who envisioned the need for a permanent home for the Society has given us one of the finest private medical libraries, operated entirely by a medical society, that there is in the country.

With such assets there is little wonder that we have had the clear signal to go ahead with our important 134th annual meeting on May 16 and 17. As one of the few medical meetings in the East, this war convention will stand out as a vital one to all physicians in this area. Every member of the Society should make plans now to be in attendance in order to profit from the outstanding lectures that will be given.

The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society,
106 Francis Street, Providence, Rhode Island

THE KENNY TREATMENT OF POLIOMYELITIS

Recently an article was published in a widely read popular magazine, concerning the so-called Kenny treatment for anterior poliomyelitis. The author, a layman, objected vehemently to the adverse findings of an investigating committee, and left the impression that this was merely another instance of the deep-rooted inertia of the medical profession and their unwillingness to accept new discoveries and methods which might originate outside their own exclusive circle.

Ordinarily, such an article would not call for any special comment. In view however of the wide circulation of this magazine, it is probable that many physicians in this neighborhood may be asked about the matter. Accordingly a brief review of the various circumstances attending the institution of this treatment, and the later investigation would appear to be of some service.

Early in 1940 Sister Kenny, a nurse of long experience, came to this country from Australia. She was said to have worked out a method of early treatment of poliomyelitis which had proved to be of considerable value in her practice at home. She was soon given adequate facilities in Minneapolis to try out her methods of treatment, and later many interested physicians and others visited this city to observe her methods and to obtain instruction in them.

Unfortunately from the very start there was unrestrained publicity which became worse as time went on. Results were claimed in many instances long before the time required for a fair appraisal. Claims and counter-claims were made by her proponents and opponents. The physicians who visited Minneapolis remained for varying periods of time. Some went away fully convinced of the revolutionary importance of her methods, while others remained skeptical.

Meanwhile various publications appeared, tending to add to the confusion. Incidentally it gradually appeared that there was not only a Kenny method of treatment in early poliomyelitis, but also a Kenny "concept" of the nature of the disease, which was in direct opposition to the generally accepted ideas of the pathology and clinical course of this infection.

It was Sister Kenny's contention that the most damaging factor in early poliomyelitis was not the degeneration of the nerves resulting from the injury to the anterior horn cells, but the so-called "spasm" which was said to develop very early in affected muscles, and said eventually to lead to degeneration if untreated. She believed that the flaccid muscles were essentially normal.

Another important factor was that of "mental alienation", where the muscles opposed to those

in "spasm" became divorced from the patient's mental control. Kenny believes that these muscles become permanently paralyzed and atrophied if steps are not taken early to restore them to normal action.

In view of the confusion and the contradictory claims, an investigating committee was appointed at the 1942 meeting of the American Medical Association. This committee was created following a resolution passed by the Orthopedic Section of the association. The committee was a joint one, appointed from members of the Orthopedic Section and also from the American Academy of Orthopedic Surgeons. It consisted of seven orthopedic surgeons from various parts of the country, all of them prominent in their profession, and all occupying important teaching positions in medical schools.

The committee in the course of its study visited a total of 6 cities and 16 clinics, some of them being visited two or more times. A total of 740 patients were examined, approximately 650 of them treated by the methods advocated by Sister Kenny. The committee finally reported to the American Medical Association at its annual meeting in June 1944, the investigation having taken approximately two years.

In brief, the committee felt that the following are the essential points in the Kenny treatment:

1) Active treatment, including muscle re-education is to be begun as early as possible. 2) The patient is maintained early in the normal standing position. 3) "Spasm" and pain are treated by means of hot fomentations applied according to a rigid technique, and continued until "spasm" is relieved. 4) Extremities are carried through as wide a range of movement as could be tolerated, several times daily. 5) No splints or braces are to be tolerated. 6) The respirator should not be used on any patient. 7) Patients and their families are encouraged to believe that complete recovery would ensue, or in the event of residual paralysis that the treatment was not instituted early enough or had been improperly administered. 8) All improvements are attributed to treatment, and no spontaneous recovery or improvement is recognized. 9) Balneo-therapy is an important adjunct to the foregoing.

The committee reminded us that over 25 years ago Lovett of Boston formulated a method of muscle re-education essentially similar in principle to that of Kenny, and this system has served as a very satisfactory basis for orthopedic treatment for many years. They believe that respirators have saved many lives, and should be used for patients with sufficient paralysis to embarrass respiration. Severe criticism was made of the oft-repeated statement of Miss Kenny to patients who came to her after treatment elsewhere that "had this patient come to her early" the disability would have been prevented. Such statements are not founded on facts. Spontaneous recovery in poliomyelitis varies in many cases and in different epidemics. It ranges often from 50 to 80 percent.

The committee believes that the concept of spasticity is of dubious value. It may be important in occasional cases and relieved by heat, but the importance has been grossly exaggerated.

Patients were seen receiving Kenny treatment who showed no muscle involvement at any time, yet Sister Kenny assumed credit for their satisfactory results, ignoring the factor of spontaneous recovery. Kenny's objection to muscle examinations, and the consequent lack of accurate records is to be condemned. If carried out carefully and with judgment, these examinations are not harmful to the patient. The use of continuous hot packs with minimal evidence of spasm is of questionable value, and an unnecessary waste of manpower and hospital beds.

The committee objected also to Miss Kenny's repeated statements that under "orthodox" treatment only 13 percent of patients recovered without paralysis, while under her treatment over 80 percent recovered. The committee felt that this was a deliberate misrepresentation of the real facts of treatment by other methods. They attributed this to her over-zealous desire to promote wider adoption of the Kenny treatment. The claim of 80 percent has not been supported by accurate statistics in a significant number of cases.

Enough cases were seen in which Kenny treatment was given very early to demonstrate that this does not prevent or even minimize the degree of permanent paralysis. Several cases were seen by the committee in which paralysis progressed after Kenny treatment was instituted. On the whole, no satisfactory evidence was presented to the committee to prove that institution of very early treatment will alter the course or extent of paralysis in any case.

While the committee disapproved and condemned the wide publicity which has reached the public and many members of the medical profession, it acknowledges that this has stimulated the interested physicians to revaluate the known and proved methods of treatment of this disease, and to treat it more effectively.

THE VETERANS' HOSPITAL

Perhaps Davis Park is the best site for the new veterans' hospital. There is little doubt that regardless of anyone's opinion to the contrary the new Facility will be located there. The fact that no medical advice on the situation was sought from local resident physicians, although the members

continued on next page

of the profession in Rhode Island will undoubtedly be called upon later as consultants to give medical and surgical care to the veterans hospitalized, is but another example of the exercise of administrative authority at the national level with disregard for local opinions.

We want the best possible hospital care for all our citizens, whether they are veterans or not. We feel a deep sense of gratitude to the men and women who have actively participated in combat and who have been injured in the performance of their war duties, and we, too, demand the best medical and hospital care for them. And when it comes to the matter of where to locate the hospital in our state, if the Veterans' Administration thinks that Davis Park is the ideal site, then the decision is theirs. But we do wish that their representatives would be more consistent in proving their case.

For example, in defense of the site, at the Assembly hearing on the proposal for the City of Providence to donate the use of as much of the park as needed, the spokesmen for the Veterans' Administration built their argument on the careful survey of all possible locations in Rhode Island, the competence of the agent who came here from Washington to inspect and choose the site (a man whose 22 years of experience in selecting the Administrations' hospital facilities throughout the country was cited as beyond question), and the imperative need for the central location "within four minutes ambulance ride from the railroad, bus and street railway terminals".

If all this is true it should be borne out by the experience of the Administrations' action in building veterans' hospitals throughout the nation in the past twenty years. And if that is the case why was the 1100-bed general hospital for Pennsylvania placed in Aspinwall, a town of less than 5,000 persons? Why was the new Massachusetts general hospital placed in suburban West Roxbury, far out of metropolitan Boston, and the older facility at Bedford, even farther beyond the city limits? Why Connecticut's in Newington, fifteen miles out of Hartford? Why Michigan's at Fort Custer? The new 2,000 bed facility at Hines, Illinois, not in Chicago? Why the Vermont-New Hampshire hospital at White River Junction, a town of less than 3,000 population? Why the Kansas at Wadsworth? Why . . . . .

Why go on through the entire list. The experts say Davis Park. We hope the veterans like it.

THE AMERICAN CANCER SOCIETY

Each year at this time we are pleased to support the Spring Campaign of the American Cancer Society. There are many reasons why we should join enthusiastically in promoting this great work. We think we may be pardoned if we first of all speak of the personal grounds on which this is brought peculiarly home to us.

Two of the most dynamic and capable leaders who are aiding greatly in making a success of this relatively new national effort for the betterment of mankind live in our midst and we who know them well realize that they are only playing true to their previously demonstrated forms when they take such active and prominent parts in an important work. If you want something done get a busy person to do it.

Dr. Herman C. Pitts, despite the added professional duties placed on his shoulders by the war and the yeoman work we all know he has done for our State Medical Society, has been for two years President of the American Cancer Society and is now Chairman of the Board. Any small community not a great medical center can well congratulate itself when one of its members forges to the top of such an enterprise.

Mrs. James C. Carmark had demonstrated by her activities in Women's organizations here that she was a natural choice for State Commander of the Field Army of the American Cancer Society and anyone acquainted with the work may doubt if there is a more active and efficient commander in any of the states.

Not many years ago tuberculosis seemed an even more terrible and uncontrollable scourge than cancer. The fight against it was organized on a national basis and although the disease is in a sense incurable the results achieved are remarkable and gratifying. But one sequela of this and other health measures has been that more people reach the "cancer age."

Dr. Clarence C. Little, Managing Director of the American Cancer Society says that there are 17,000,000 living Americans who will die of cancer unless something is done. At least 5,500,000 can be saved from death. This saving can be done only by intelligent and early handling of cases. Research has produced astounding results in other diseases and it is studying cancer on a tremendous scale. It is only reasonable to hope that great things may follow from this.

To make certain that the public gets the full advantage of what we know now, and what we hope to learn, requires organization. Therefore for Research, Service, and Education support the American Cancer Society.

FRESH AIR FOR HEALTH

EDITOR, *Rhode Island Medical Journal:*

Your editorial in the March issue of THE JOURNAL under the title Air Conditioning seems a challenge to me. Please excuse the absence of a bibliography to authorize any statement which I may make. As you made some references to past history in a personal way please forgive me for retaliating in a similar tone.

In my medical school years I had the pleasure of acting as camp doctor for three summers in a boys' camp on the shores of Moosehead Lake in Maine. These boys lived in tents. On every day and night when it did not rain the front and rear flaps were open and the walls were tied up. Many nights the boys moved their cots outside and slept under the stars. I went with them and you, Doctor Chase have often done the same thing. Nights are cool in Northern Maine. We never had respiratory disease among the boys except when their parents imported infectious colds over week-ends.

Let me say that your authority who stated that we should sleep with our windows closed to avoid pneumonia should realize that all respiratory diseases are either bacteria or virus contact diseases. These bacteria and viruses do not ride on the wings of the wind in day or night. Further, these infecting agents thrive well in stagnant air and not in moving air. Persons who harbor a chronic sinus condition or those afflicted with allergy involving the upper air passages may have a flare up of their symptoms if they sleep in a draught between oppositely opened windows in a bedroom. Fresh air admitted through an open window which does not cause a draught does not produce respiratory disease.

Now for some past history. What do we mean by the American Way, an expression oft heard on the radio and in political speeches. I gather from the context of these talks that we refer to our liberties in the matters of wine, women, dance and song. My idea is a bit different if we refer to the American Way of Health. The rules are simple yet seldom followed, viz—a diet consisting of all the essential vitamins, including D for all, amino acids and fats—a hard day's work of eight to ten hours—frequent vacations in the open air rather than frittering the time away in a city hotel—finally eight hours of rest in a well-ventilated bedroom. The air in the room does not need to be at freezing temperature but regardless of weather some air should enter the room from the outside.

How closely do we people of Rhode Island live up to such a standard, particularly in regard to the matter of fresh air? Providence provides an opportunity to study the racial habits and manners of many different nationalities. These differences in the pattern of life have gradually lessened and the passing of each year brings us a little closer to the desired time when we will all proudly call ourselves Americans. Some nationalities still shout aloud their allegiance to their one-time fatherland even though their progeny have for several generations been Americans. The fact that we are not all willing and glad to accept the country of our adoption is one of the things which lead to the oft asked question "What is Wrong with America"? This question would be unnecessary if we stopped calling ourselves Swedes, Germans, Irish, English or Armenians. Please excuse the aside.

In the early years of my practice it was my pleasure to serve in a rapidly growing clinic for children on Federal Hill. There came to this clinic many mothers who had been born in Italy. They spoke the native language and handled their babies according to the customs of their native land. Each baby was rolled up in a binder eight to twelve feet in length. These babies slept in rooms with the windows closed and in the winter months seldom were taken into the open air.

At this time Dr. Chapin appointed me as city physician to the sick poor but he gave me the privilege of attending the children only. Dr. Harvey B. Sanborn attended the adults on the same health program.

The incidence and mortality of pneumonitis on Federal Hill was frightful. At the same time I worked for hours in well baby conferences among people of a higher economic group but the habits were the same and the mortality from pneumonitis was high. The infant mortality at that time was 115 to 130 per thousand living births in the first year.

Space prevents the tabulation of the factors which have absolutely changed this picture. Above all in the transition was the inherent intelligence of the Italian people and their willingness and cooperation to learn the American Way stated above. Their natural love of vegetables and fruit made our pathway in teaching the proper diet easy. Today the children of parents, all Americans, sleep in rooms with fresh air coming through open windows. Their infants sleep in the open air throughout the day. Today thanks to the fresh air and American Way of life so readily adopted by the parents of these children of Italian extraction, which it has been my pleasure to attend, there is no more severe respiratory disease on Federal Hill than in any other part of the city.

continued on next page

SCIENTIFIC MEETING — MAY 7

At the regular meeting of the Providence Medical Association to be held on Monday, May 7, at the Medical Library, the following program will be presented:

"HUGH OWEN THOMAS: THE APOSTLE OF REST"

ROLAND HAMMOND, M.D.

"THE USES OF PURIFIED HUMAN FIBRINOGEN AND THROMBIN IN MEDICINE AND SURGERY"

ORVILLE T. BAILEY, M.D., of Boston

FRESH AIR FOR HEALTH

continued from preceding page

In the early years of my practice there were many people of Irish extraction living in the north end of Providence and in Olneyville. Their children likewise slept in rooms with closed windows. Pneumonitis was rampant in this group. Now all this has been changed. The present generation of children sleep in rooms with open windows and in these sections of the city there is no longer the frightful toll of death from respiratory disease.

Again, children of Scandinavian, English and Armenian descent sleep in rooms with a flow of fresh air and the incidence of respiratory disease in this group is low.

Now there is the opposite side of the picture. There are still many people contacted in practice who adhere to the idea that there is something wrong with night air and who do deprive their children of air through an open window. The bedrooms are superheated, there is an excess of coverings. The children sleep restlessly, throw off the bedclothes and cry out many times in the night disturbing the whole household. These children have a characteristic pallor, fatigue easily and for the most part are highly susceptible to respiratory disease. This is still and always may be a problem. There may be more dampness in the air at night but the air constituents remain the same.

All people may contract respiratory disease but I believe that there is less among those children who sleep with their windows open.

Dr. Chase, I think you as well as many of us, dislike all this talk about the elimination of fresh air from our surroundings. It is all a part of the softening influences which beset the American people. Heated automobiles driven with closed windows, superheated homes, too little exercise in the open air, the tendency to city life rather than life in the country all betoken a disintegration of the hardy principles upon which this nation was built. Rome lasted a thousand years. Our country is less than two hundred years old. How long will it last at our present rate of decline away from the foundations which our forefathers built?

Respectfully yours,

HENRY E. UTTER, M.D.

NATUROPATHIC LEGISLATION AND EDUCATION

continued from page 253

arts, and to grant degrees, and since that time the sessions have been conducted in Miami, Florida. The corporation has no stock and is not conducted for profit."

Upon request the Florida Medical Association investigated the school in July, 1944, and the following comment was submitted by Homer L. Pearson, M.D. of Miami, editor of the Florida Medical Journal:

> **"On July 13, 1944 I visited the Southern University of Naturopathy and Physio-Medicine at 1321 S. W. 4 Street, Miami, Florida, and contacted the secretary of the institution, Dr. Casey.**
>
> **"The university plant consists of a small five room wooden building on a fifty foot lot in a residential section of Miami. The building is old and dilapidated and is used as the Doctor's office for the practice of Naturopathy. Dr. Casey informed me that classes have been suspended for the duration. She was not sure that the university would open again, however, she stated that they had regular Board of Directors meetings in order to keep their Charter alive. The largest thing about the university is its sign and I asked Dr. Casey what other colleges of Naturopathy were there in the United States. She informed me that some Schools of Chiropractic give courses in Naturopathy but hers is the only college giving only courses in Naturopathy. Their course for study requires four years of nine months each for completion. However, since the majority of their students are working people their classes are held only at night. It is a crime for such a place to be classed as an educational institution of any type much less one teaching the healing arts. There are a number of its graduates in practice in the State of Florida and it will always be a mystery to me how any such place obtained a Charter as a University."**

THE UNIVERSITY OF NATURAL HEALING ARTS
1600 Logan Street, Denver, Colorado

A communication directed to this school asking for information regarding its courses in naturopathy was acknowledged but no catalog or factual data was submitted. The acknowledgment of the inquiry stated —

> **"Laws in each state are different, so we would suggest that you inquire of the local Doctor of Naturopathy if interested in Rhode Island laws, or write to Dr. S. Gershanek, Sec. 1947 Broadway, Suite 411, Lincoln Arcade Building, New York City, for law governing any state in particular.**
>
> **"We require a high school diploma for entrance; the tuition is $25.00 per month, hours, 4,000 sixty minute hours; after graduation degrees are given in D.C., N.D., and D.P.T."**

The Dr. S. Gershanek referred to in this letter is believed to be the same doctor who was Chancellor of the University of Healing Arts which opened in Hartford, Connecticut, in the fall of 1935 and suspended all instruction a year later when the State Commissioner of Health called attention to the fact that the school was violating the state laws in that it had not secured approval of the

State Board of Education and the General Assembly. In the preliminary announcement of this University, issued in 1935, Dr. Gershanek was listed among other titles, as dean, New York School of Chiropractic, dean, American School of Chiropractic, and American School of Naturopathy, editor, The Chiropractic and Naturopathic Directory, and editor, The Chiropractic Standard.

THE WESTERN STATES COLLEGE
1536 S. E. Eleventh Avenue, Portland, Oregon

Chartered by the State of Oregon, the Western States College offers courses leading to the degrees of Doctor of Chiropractic and Doctor of Naturopathy. Either degree is granted upon the successful completion of the four year course, and after receiving either the D.C. or N.D. degree the graduate may secure the other degree by an additional 4 months work. In addition the College confers the degree of Bachelor of Therapeutic Arts on "students who have completed the 4-year course for the degree of D.C. or N.D. and who maintain an average of 85% in all subjects and prepare a thesis of not less than 5,000 words approved by the Faculty. The degree of Bachelor of Therapeutic Sciences is granted: (I) To one who has acquired at least two degrees in therapeutics from reputable schools (one of which must be either D.C. or N.D.) and who has received his B.T.A. degree from Western States College; and in addition thereto has practiced at least 12 months, and completed a thesis discussing and analysing the philosophies of the standard healing arts; or for original research in non-medical healing; (II) By consent of the college Faculty for outstanding work in non-medical therapeutics. Note: B.T.A. degree is, in all cases, one of the pre-requisites leading to B.T.Sc. degrees, except where granted under clause II."

The College has as its director, Dr. A. Budden, D.C., N.D., B.T.Sc., who was for some years Dean of the National College (of Chiropractic) located in Chicago, and editor of the Journal of Chiropractic.

Conclusions

There is no school that confines its teaching to naturopathy. On the contrary, naturopathy appears in every instance to be nothing more than part of the course given for the training of chiropractors.

For the most part the institutions checked appear to be promotional enterprises dispensing diplomas to anyone who will pay the tuition fee, and granting not one, but several degrees for one course.

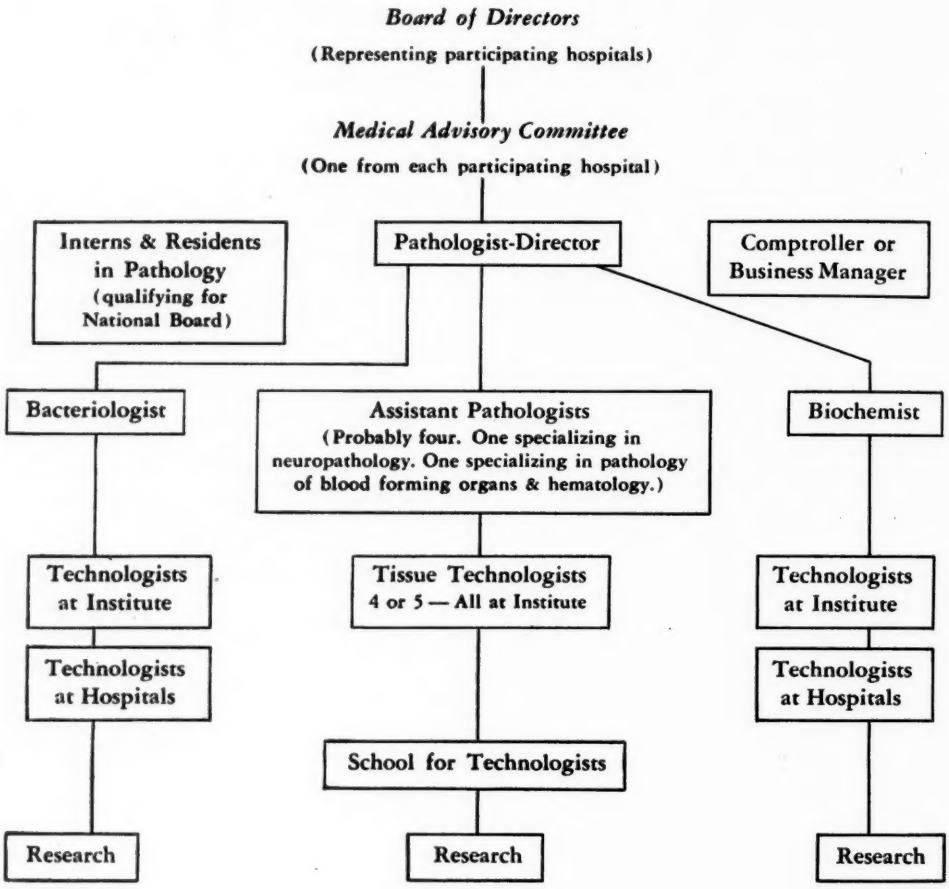
It is evident that the liberal grant of degrees has for its purpose the accommodation of the individual in his quest for state licensure, rather than for qualification as a healer in any one phase of the healing art.

None of the schools checked has apparently ever been surveyed by any approved educational authorities to justify the extravagant claims made in their brochures and catalogues relative to equipment and teaching personnel.

There has been collusion, in at least one instance, between one of the schools checked and proponents of state legislation for the regulation of naturopathy.

The courses of study in naturopathy offered by the schools are in no instance of a sufficiently high standard to justify legislative recognition of the graduates of such schools in Rhode Island to practice Naturopathy.

A RHODE ISLAND INSTITUTE OF PATHOLOGY



Two or more mobile technologists who would fill in at hospitals while their regular technologists were at the Institute for additional training and during vacations.

Surgical specimens collected each day and examined at central Institute. Pathologists would go out from Institute to hospitals for frozen sections and autopsies. All serology would be done at Institute. Less common and more complicated chemical and bacteriological procedures done at the Institute. All technologists at the hospitals under the supervision of the Institute.

Costs to be shared by participating hospitals on basis of number of beds or other arrangement made by board of directors. Each hospital would continue to charge its own patients for laboratory work according to its own plan.

(This chart and the recommendations included therein are offered only as a preliminary suggestion. Each participating hospital would have to be considered individually in developing such a program.)

A RHODE ISLAND INSTITUTE OF PATHOLOGY

THE Committee on University, Hospital, and Medical Society Relations of the Rhode Island Medical Society is suggesting the establishment of a central Institute of Pathology to serve many or all of the hospitals in the state. It is the belief of the committee that all hospitals, hospital staffs and their patients would profit from such an arrangement. The smaller hospitals would perhaps benefit most. It has also been suggested that such an institute might furnish laboratory service to individual physicians.

The pooling of pathological material would provide for the participating pathologists an amount of experience and resulting ability far above that now available to any pathologist in the state. Each man could give special attention to some part of pathology that especially interested him and become an expert. (For example: neuropathology, hematology, gynecological pathology, the pathology of children, etc.). At the same time the group association and the group study would make him a better general pathologist. Puzzling pathologic problems would receive the combined study of the group instead of the opinion of one man. Each hospital would have the advantage of all of this special knowledge — small and large alike.

The staff of the institute would be large enough so that each hospital could have the personal attention of these experts for frozen sections, conferences, staff meetings, tumor clinics, teaching of interns and residents, and perhaps some lecturing to student nurses.

The institute should also have experts in bacteriology and biochemistry and the work of all technologists doing such work would be supervised by them. All such hospital technologists would be kept up to date by periodic review and training at the central laboratories. These experts, too, would be available for conference and teaching.

A system of residency in pathology, preparing young men for National Board certification would be an important part of this organization. These young men would receive a part of their training (3rd or 4th years) as resident pathologists in the larger of the participating hospitals.

Such an organization should prevent much duplication of equipment and of personnel. It would make more laboratory service available to all hospitals and should improve the quality of this work. It is thought to be in line with the trend of medical thought and would place Rhode Island in a position of leadership. It would forestall governmental attempts to take over this phase of medicine. It would benefit all citizens of Rhode Island.

We urge all physicians to give this proposal serious thought. We hope that the staffs of all hospitals will discuss it and consider it as related to their own institutions. Medical groups should consider it from a medical point of view. Is it desirable for the physician and his patients? We are aware that there are complicated financial and organizational aspects. These may be left for later consideration. We believe that if the physicians of Rhode Island favor the proposal and the staffs of hospitals ask for it that there is a good chance of its being accomplished.

We wish to suggest that this is a statewide proposal. It must be thought of in terms of all the hospitals concerned, of all the physicians of the state, and of all the citizens of Rhode Island who look to us for medical care. These broader aspects together with the interests of individual institutions and medical groups should form the basis for discussion and decision.

The committee would like to be invited to meet with hospital staffs to discuss this project.

COMMITTEE ON HOSPITAL, UNIVERSITY AND MEDICAL SOCIETY RELATIONS
ALEX M. BURGESS, *Chairman*
B. EARL CLARKE
HARMON P. B. JORDAN

ACRYLICS IN GENERAL DENTISTRY*

FRED A. SLACK, JR., D.D.S.

The Author. *Fred A. Slack, Jr., D.D.S., of Philadelphia, Pa.*

IN recent years the scope of general dentistry has extended beyond the realm of replacement alone. There are relatively few dentists worthy of the name who examine a patient with the single thought of replacing lost dental structures. A simple filling's relationship to the cavity is small compared to its relationship with the tooth, the approximating teeth, the opposing teeth, and their contacting mucosa and supporting structures. The replacement of a single tooth bears a direct relationship not only to its alloted space, prepared stump, but to its surrounding members. A bridge of pontics and abutments does not simply restore missing teeth, it restores continued vitality to the entire oral cavity. A full upper denture has a responsibility as much to the opposing teeth as it does to its covered structures. An edentulous mouth remains healthy only in so far as those structures are preserved by the skilled use of modern prosthetic materials. Conservatism coupled with constant improvement are necessary to attain this end. Conservatism must not be backward. It must combine the application of new conceptions with proven experience. In dentistry, it is the conservation, preservation, and improvement of existing dental structures.

With this preservation in mind, there has been one chemical substance, a complex organic salt, that seems to promise more for conserving, preserving and improving existing dental conditions than the advent of the amalgam filling, gold inlay, vulcanite denture or porcelain tooth. This organic salt or ester is METHACRYLATE. There are many methacrylates and while using them it is well to understand their properties and behavior. To many of us methacrylate is simply a powder and liquid which can be combined quite easily and pressed and processed into various dental restorations. To others it is necessary to know that the powder (polymer) and liquid (monomer) are chemically carbon, oxygen, and hydrogen, of the same molecular formula. The polymer is hard simply because the molecules are all joined together with rigid chain-like binders. The polymer and monomer may be mixed together and pressed under heat to form a solid piece of methacrylate or the liquid itself can be made to harden or polymerize to form a solid piece of methacrylate. By means of metal molds, high temperatures, and pressures, the powder itself can be pressed into a solid piece of methacrylate.

No matter which way the solid methacrylate is formed, providing it is done correctly, all of the resulting pieces are substantially of the same physical hardness as they represent actually a definite molecular formula. However, like other salts methacrylates have a great many prefixes. Although sodium chloride is perhaps the commonest known of the chloride group, there are also calcium chloride, potasium chloride, and many others. Likewise, there are many methacrylates. Methyl-methacrylate is the hardest and is the main methacrylate used in the majority of our denture materials. As methyl-methacrylate is the hardest methacrylate, it is also used pure for good crown and bridge restorative materials as well as acrylic teeth. The softer methacrylates such as ethyl, may be used as a softener or plasticizer to give better working properties to the denture materials. This would then be called a co-polymer. It may be mentioned as this time that all efforts to combine the methacrylates with other plastics such as styrene, vinyl, etc. have resulted in more inferior properties than those gained by the blend. It is pointed out if blends of plastics gave better properties as sometimes claimed, that our bomber noses and other commercial jobs requiring ultimate strength of all types, would not still be using pure methyl-methacrylate in the form of Plexiglas or Lucite. The addition of materials other than plastics impart even worse properties. These are in the form of plasticizers, solvents, lubricants, dopes, etc. which are added commercially to make molding easier on cheap products, and dentally to make possible the use of commercial molding-powder regardless of its after effect. Many so-called toxic allergies to methyl-methacrylate have been traced directly to the solvents, plasticizers, or dopes used in their compounding. Dental methacrylate requires none of these adulterants.

All dental methacrylate may be measured, mixed packed and processed substantially the same. The fact that one may allow itself of exceptional ease of handling may even indicate contained plasticizers

continued on next page

*Presented before the Rhode Island State Dental Society at its 67th Annual Meeting, at Providence, January 24, 1945.

or other harmful ingredients. I am certain none of you would go to a surgeon who was notorious for his shortcuts regardless of consequences. You have often yourself said to a patient while painstakingly removing that last bit of decay, "this may hurt a little". Likewise, it is unreasonable to expect the best results from shortcut procedures and materials even though the consequences may not be a matter of life and death as in the case of a surgical operation. Your responsibility nevertheless is the same. First, we shall discuss denture acrylics.

It is impossible to determine by the odor of the polymer or monomer whether it is good or bad. Separate batches of material have arrived from both Rohm & Haas and du Pont with little similarity in odor. Fresh polymer often smells stronger than polymer which has been exposed to the atmosphere for some time. Fine grain polymers smell stronger than coarse grain. Monomers frequently vary. Purity is better associated with the manufacturer.

The common proportions for mixing are, polymer three parts — monomer one part. Spatulation is important only from the standpoint of complete dispersion of pigment and physical distribution of the powder and liquid. The polymer will first appear dry, then thorough saturation will occur. The gel time of this mix depends on the formula of co-polymer used by the manufacturer, and the temperature of the polymer, monomer and jar. It sets quicker when warm. It must now be left covered until the gel or doughy state has occurred which will be between three minutes to one-half hour. This occurrence is that state in which the doughy mass may be separated from itself without connecting strings. It is now ready to pack. Packing is best accomplished by using a moderately warm flask. Separate the dough into small pieces and pack from periphery of flask toward center. By the use of moist cellophane between the halves for separation, pressure is applied until flask is substantially closed. Test packing is accomplished by adding further pieces of dough until mold is overcompressed. The flask is then cut away and pressure is applied finally. Premixed gel, powder and liquid dough, regular presses, spring presses, injection presses have all been used with success. Care must be taken whatever method is used and while underpressure may be the fault of one, overpressure can be applied with the other. For general work the simplest method is the one of choice, i. e. — simple presses, and flasks, with good time-heat factors.

Processing divides itself into two simple processes. First, we must slowly initiate polymerization while dissipating the internal exothermic heat evolved. For practical purposes 158° for one hour will accomplish this. It must be held longer for larger cases. One half hour suffices for jackets and bridges. Second, we must raise the heat enough to carry polymerization or hardening to completion. One-half hour at boiling is a practical method of accomplishing this. It is claimed that these two objects can be carried on simultaneously by keeping the flask at 180°F. for three hours. While not disputing this it is felt that after the preliminary phase is over — a one-half hour boil is necessary to insure complete polymerization. At least this can do no harm. Although it is recommended that all cases be bench cooled before opening the flask, it has never been found detrimental to institute immediate cooling under cold water. The main object to keep in mind is that the deture must be completely cooled before flask pressure should be relieved. Dr. E. Howell Smith of the University of Pennsylvania claims that a secondary air polymerization or hardening occurs during the subsequent twenty-four hours after processing, and that all cases should be left on the models for that time. This also can do no harm.

The use of tin foil substitutes and their efficiency merits attention. Although it is conceded that a tin foiled case leaves little to be desired, the use of separators will materially reduce time. Furthermore, there is increasing evidence that a good separator, well used, will give a denser case than tin foil. This is no doubt due to a more even transfer of heat throughout the flask. The best separators are of the compound-alginate-suspension type that deposits a film only on investment surfaces. Otherwise, great care must be exercised in not allowing the separator to touch the necks of the teeth, gold retention lugs or repaired surfaces. Care must be exercised in not confusing the alginate separators with those of simple starch or silicate of soda preparations. The main requisites for the successful use of a separator are: —

1. A smooth, hard outer investment.
2. Complete wax elimination.
3. Application of the separator until an undisturbed, smooth, glazed film is apparent.

The thickness of such an alginate film has been measured to be plus or minus 5/10,000ths of an inch thick. The advantages of a thin film are quite important when considering the model side.

When considering the merits of acrylic teeth a few considerations should be given to the following facts: —

1. They are new and the technique and treatment has many times contributed toward their failure.
2. The use of solvents, flaming the teeth during wax-up, and vulcanization, is contra-indicated, and will result in tooth failure.

3. Their method of manufacture combined with a great demand has no doubt contributed toward occasional defective teeth being released.

In spite of the above factors the great preponderance of successful restorations has proven beyond a doubt their practicability. Recent tests by the Armed Services and their acceptance has further born this out. Now with routine technique and new injection molded teeth failures should be a thing of the past. Many cases have been recently observed passing their fourth year of mouth use, which are still in perfect condition, showing no extreme wear or disintegration. Some of these restorations were against abrasive porcelain teeth. Practically all cases of extreme wear of acrylic teeth have been traced definitely to either defective teeth or damaging techniques. Acrylic teeth have certain advantages involving no impact shock, no abrasion, great lightness and strength. It is increasingly evident that injection molded acrylic teeth may be used routinely with the confidence that they will give good denture service. It is also evident that they have many advantages not heretofore possessed by porcelain.

It is now apparent that plastic jackets, crowns, inlays, and bridges are holding up remarkably well against opposing natural teeth. Some of these cases have now passed their fourth year and are giving perfect service. An original thirteen-tooth bridge placed in 1940 is still being worn after four years and is in good condition. Single jackets with or without reinforcement have become routine practice. Many original bridges failed because of large reinforcing bars. Thin rigid cast double bars are a pre-requisite for a successful acrylic bridge. Reinforcing bars should impart rigidity and attachment only. Compound inlays on the whole have been failures and they are not recommended. But original cervical, gingival, and Class I inlays are still giving good service and can be considered superior to baked porcelain restorations in esthetics and ease of construction. The technique involved in construction of acrylic jacket-crowns and inlays is simple and varies with materials used. Provided a dense esthetic restoration is obtained, the technique involved is unimportant. The materials vary between coarse and fine grain polymer. Dr. Stanley Tylman of the University of Illinois has stated that the finer grain polymer gives routinely denser results.* The techniques divide themselves between (1) a system of mixing the gingival and incisal shade in separate jars and packing them after the dough state has been reached and (2) placing a fine grain polymer in the mold, gingival and incisal shades in their respective position and adding the monomer slowly at the incisal tip edge. The above technique procedures are repeated until the proper shade blend is accomplished upon two or three test packs. Perhaps the simplest procedure is a combination of the two techniques utilizing a dough mix gingical shade completely test packed in the mold. The incisal portion is then carefully cut away and the dry incisal polymer placed in the incisal section. Monomer is then applied slowely and the incisal is then built up covering part of the gingival making controlled blending possible. A further use of the restorative material is in constructing raised bite splints. This is only recommended where sufficient bulk can be obtained, approximately 1/8th inch at all sections. Otherwise, the strain of occlusion is liable to fracture the splint. Restorative acrylics may be used routinely for jacket crowns anterior and posterior, bridge pontics anterior and posterior, and one surface inlays. One precaution only is necessary — opposing abrasive natural teeth should be realigned and polished smooth. It goes without saying that to obtain these results a polymer and monomer of known purity must be used. Both should be pure unadulterated methyl-methacrylate.

Cementation of acrylic crowns, bridges and inlays is supposedly a problem. In doing considerable work involving jacket crowns, bridges and one

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RHODE ISLAND STATE DENTAL SOCIETY

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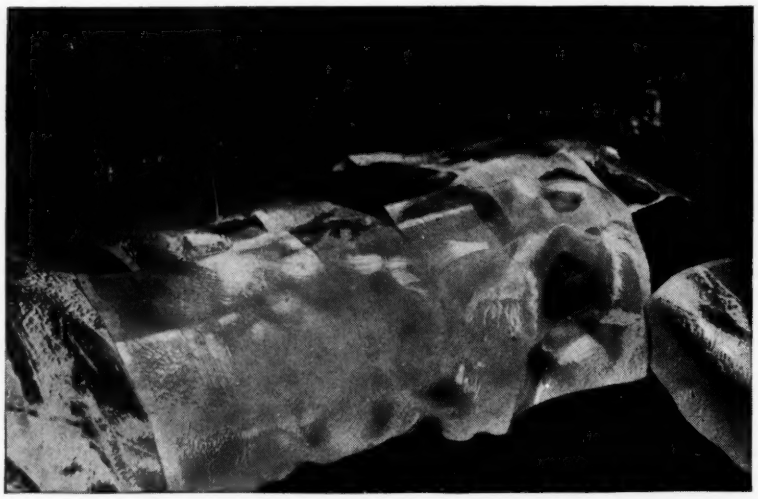
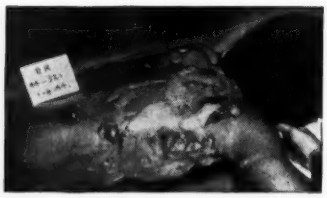


Uses of Fiberglas in Medicine*

Physicians, surgeons and others engaged in medical research have, in recent years, employed various Fiberglas materials experimentally and have found them uniquely fitted for certain uses.

For example, Fiberglas cloth (ECC-11-108) was used to help measure the protein loss in the exudate from surface burns. As illustrated, the Fiberglas cloth was placed next to the burned skin of a 12-year-old Negro girl. It is the first layer of a bandage devised to collect the exudate in order accurately to measure nitrogen loss from the burned skin surface. The patient was admitted to a Detroit hospital in January, 1944. The burn, caused by hot water, involved about 12 per cent of the body surface. "The burn healed rapidly," says the report in *Surgery*, "and the amount of nitrogen lost in the exudate from the burned area diminished as healing progressed."



This method of determining the magnitude of the protein loss from the burned surface gives physicians a comprehensive picture of the metabolic upset for the first time and thus will permit improved replacement therapy.

Fiberglas is glass in fiber or filament form. Glass textile fibers, ranging in diameter from four ten-thousandths of an inch to less than two ten-thousandths of an inch are formed into yarns which are woven into a wide variety of textiles.

Fiberglas is an inorganic, nontoxic, nonallergenic, nonsensitizing and chemically stable substance which produces no harmful effect upon human tissue. It is pliable and possesses great tensile strength. It has high dimensional stability, resists high temperatures, steam, corrosive fumes and acids (except hydrofluoric). Fiberglas is nonhygroscopic and noninflammable. It is easily sterilized and resterilized, and in a special form is radiopaque.

It is the policy of Owens-Corning Fiberglas Corporation to supply samples of Fiberglas in any available form to qualified persons engaged in research. The new brochure describing such other pioneering uses of Fiberglas as:

- Tracer Threads in Surgical Sponges
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- Blood Plasma Filters
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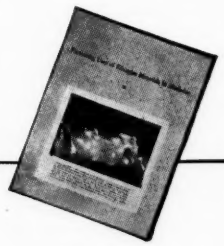
. . . may suggest ways in which Fiberglas can help solve other problems. Ask your secretary to send for your copy today. Write *Owens-Corning Fiberglas Corporation, 2036 Nicholas Bldg., Toledo 1, Ohio.*



FIBERGLAS

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Plants at: Ashton, R. I., Huntingdon, Penn., Newark, Ohio

INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., *Chairman*; Stanley Davies, M.D.; Arthur E. Martin, M.D., Elihu S. Wing, M.D., William P. Buffum, M.D.

PROGRAM

Meeting of the New England Conference of the American Association of Industrial Physicians

WEDNESDAY, MAY 2nd . . . . . *At* J. & P. COATS, INC., Pawtucket, R. I.

12:30 — 1:30 P.M. . . . LUNCHEON

2:00 P.M. . . . CALL TO ORDER

JOHN F. KENNEY, M.D., *President*

REMARKS *by* J. COLBY LEWIS, *General Manager*, J. & P. COATS, INC.

2:10 P.M. . . . . "REHABILITATION OF WORKERS UNDER THE WORKMEN'S COMPENSATION ACT AT THE NEW CURATIVE CENTER"

JOHN E. DONLEY, M.D., *Director*

(NOTE: This is the first center of its kind operated by a State in the country, and carried on in conjunction with the insurance companies. Dr. Donley will explain how the program is to be carried out in an ethical manner to the satisfaction of the employer, the patient, and the doctor)

2:45 P.M. . . . . ."TUBERCULOSIS IN INDUSTRY"

U. E. ZAMBARANO, M.D.
Superintendent, State Sanatorium, and Consulting Physician to all Rhode Island hospitals.

DISCUSSION: DANIEL LYNCH, M.D., *Medical Director, New England Telephone and Telegraph Co.*

3:15 P.M. . . . ."INDUSTRIAL DERMATOSES — TREATMENT"

VINCENT J. RYAN, M.D.
Dermatologist, Rhode Island and Memorial hospitals, and Consulting dermatologist to various Rhode Island industrial plants.

(NOTE: The discussion by Doctor Ryan will include cases that plants should or should not be responsible for, i.e., compensable or non-compensable)

3:45 P.M. . . . . ."BURNS AND TREATMENT"
(illustrated with slides)

HENRY B. MOOR, M.D.
Chief, Surgical Service, Memorial Hospital; Medical Director, Gorham Manufacturing Company.

HOSPITAL ASSOCIATION OF RHODE ISLAND

SPECIAL MEETING OF ASSOCIATION

A special meeting of the Hospital Association of Rhode Island, held on March 16th, was attended, in addition to regular members, by several members of Boards of Trustees of the various Rhode Island Hospitals and by Dr. Edward A. McLaughlin, Director of Health for the State of Rhode Island, representing Governor McGrath. This meeting was called for the specific purpose of studying and arriving at an Association viewpoint on U. S. Senate Bill 191.

The Bill, which is designed to provide Federal funds for State Surveys of health facilities and needs and for construction to meet the needs, was thoroughly explained and discussed by Mr. Kenneth Williamson of the American Hospital Association. The Bill was drawn with the thought in mind that such surveys made in each state would provide a national picture of health facilities and deficiencies; and that with the provision of Federal funds to pay a part of the cost of needed construction, we would eventually arrive at a point where the total health needs of the Nation might be met.

The Hospital Association voted to endorse the Bill without reservation. The goal is broad and idealistic. Complete hospital and health facilities to meet the needs of every individual in our country may still be a long way off, but if this Bill is passed and the surveys completed, the road ahead should be clear and the distance to travel will be measured. We can start the journey with full knowledge that there may be interesting by-paths and unavoidable detours, but also knowing that if we stick to the mapped route we will gradually near our destination.

The first move to construct our road toward complete health facilities within our own State of Rhode Island has been taken by Dr. Edward A. McLaughlin, Director of Health. Dr. McLaughlin has had introduced House Bill No. 713, which would give his department authority to receive Federal Funds for the purpose of making a complete health survey within our State.

The Hospital Association also voted to endorse this bill without reservation.

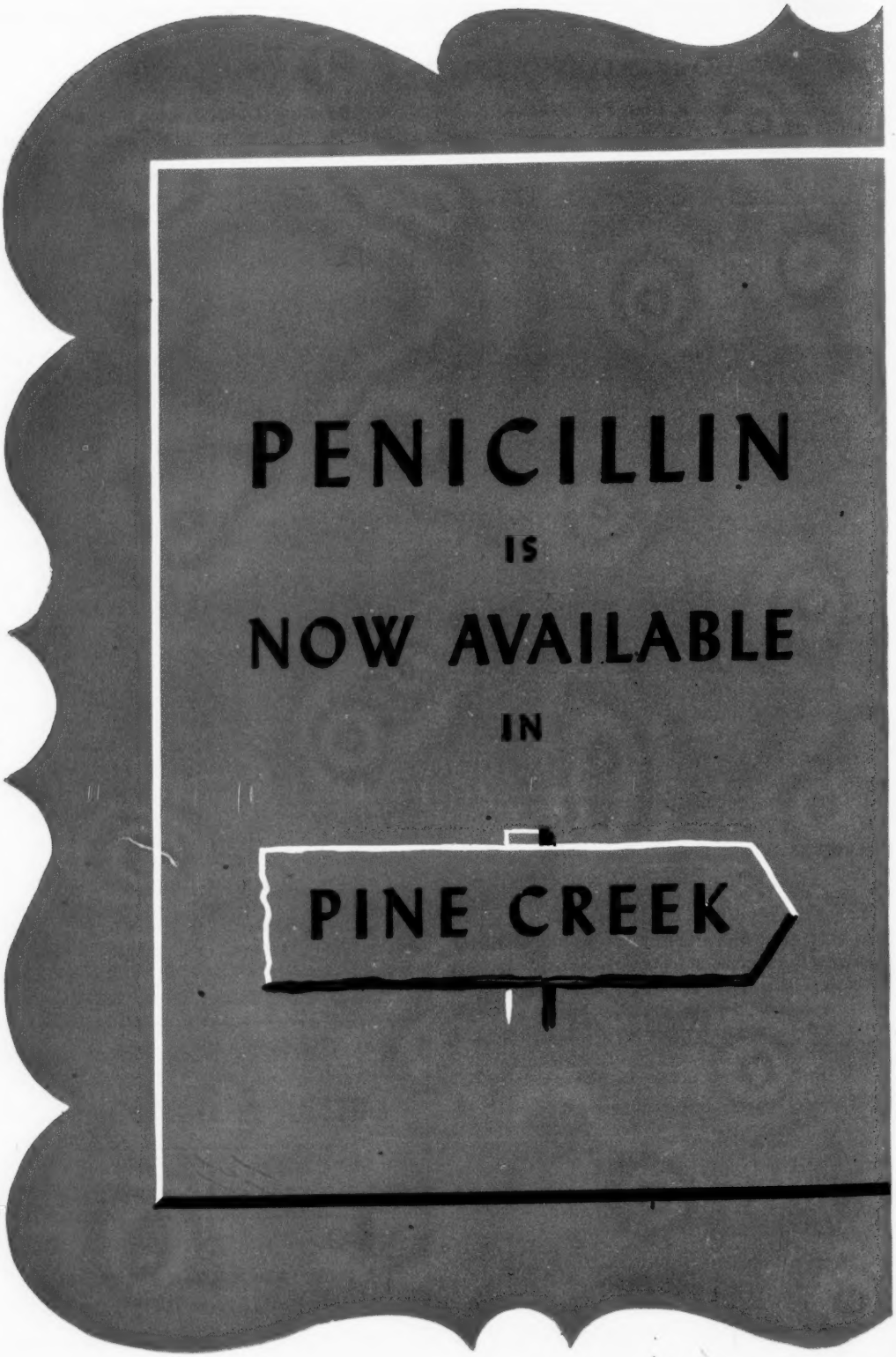
By its endorsement of these two bills, this Association has joined The American Hospital Association, The Catholic Hospital Association, The Protestant Hospital Association, The American Medical Association, C. I. O., and many State Associations, in supporting a plan which promises to provide national health facilities, while at the same time maintaining the present system of voluntary hospitals throughout our Country.

HOSPITAL EMPLOYEES IN BLUE CROSS

Within recent weeks, The Rhode Island, St. Joseph's and Butler Hospitals, have purchased the new Blue Cross plan, known as Plan C, for their respective employees. It is the hope of these Hospitals, as well as of many industries that have covered their employees under Blue Cross Plan C, that these employees will now cover their dependants under the same plan.

In purchasing this plan, the Hospitals can see no financial advantage, but feel that they are furthering the expressed aims of Governor McGrath, who has postponed the plans for Compulsory Health Insurance, in order that voluntary organizations may have an opportunity to insure the population of Rhode Island for their hospital care.

Apart from creating additional good will among their own employees, the Hospitals who have purchased this plan have taken the initial step in what may well be a state wide acceptance of and membership in Plan C, by industrial and many other types of organizations.


PENICILLIN
IS
NOW AVAILABLE
IN
PINE CREEK

DOCTORS AT WAR

ACROSS THE RHINE

Captain Thomas A. Egan, of Providence, writes that the Christmas greeting from the Providence Medical Association arrived February 6, and the December Issue of the MEDICAL JOURNAL two days later, and "it was nice to receive the kindly expression of good wishes from the society—it meant a lot, I assure you." As for the JOURNAL, "it was tops, — the first one I have received since September, and I read every word of it."

Dr. Egan reports he is Company Commander with a medical battalion with four officers and approximately 100 men under his command. His outfit has been cited, decorated and commended for its work, but as far as all are concerned the one ambition is "to get it over soon and get back to natural living again."

From caring for German prisoners at an Arkansas camp to the front lines in Europe was the move made by *Captain Edward Ricci,* of North Providence, whose experiences are among the most interesting to be reported to us. From his Arkansas post he first headed to Texas where he worked at Fort Sam Houston before being ordered across to England in July. Then came the crossing to France, nights sleeping under trees in apple orchards, the establishment of a hospital headquarters near Paris, then assignment to a hospital following General Patton's army.

Commenting on the care of the wounded Captain Ricci makes the observation that "it is marvelous to see what is done for the injured. One may read about it, but you have to see it to really appreciate it fully. It is not the surgery that saves the lives of the severely wounded, but the preoperative care that is given them in the use of blood, penicillin, sulfa drugs and plasma."

FROM THE LAND OF TULIPS — AND WAR!

In the past few weeks, prior to the break through across the Rhine, we received many communications from members in the forward lines surging through the Low countries. One of the first to report was *Captain Rodrigo P. Da C Rego,* of Providence, who is a battalion surgeon with an anti-aircraft group. Doctor Rego reported the recent receipt of the November issue of our MEDICAL JOURNAL.

From *Dr. Albert J. Gaudet,* now Captain Gaudet, of Pawtucket, we had news that since writing us of his experiences in England he has been moved into the front line forces in Holland, after travels through France, Luxembourg and Belgium since the first of the year. Dr. Gaudet reports "the welcome given us by these people who have suffered under four long years of German occupation is heart warming to say the least. They really hail us as liberators and cannot do enough to make our lot easier and more pleasant". He adds a thought that bears repeating to all at home when he writes that he has had ample opportunity to see the ravages of war in such cities as Metz, LeHavre and Liege where homes, industrial plants, bridges and com-

continued on next page

TWICE DECORATED

Award of the Bronze Star and also the Purple Heart to Captain Alphonse R. Cardi, MC, of Cranston, as reported by the doctor himself from the front lines in Germany, distinguishes him as probably the only Rhode Island physician to win two awards, and also the first to be reported, according to the Society's records, as having been wounded in action.

For heroic achievement in the Normandy break through Captain Cardi was awarded the Bronze Star last fall. Last December he sustained a wound in his left knee as the result of direct fire from Nazi artillery, and for this was awarded the Purple Heart. As a Battalion Surgeon doing "front line surgery" Doctor Cardi reports that he is with a medical unit moving into the first line of attack into Germany.

DOCTORS AT WAR

continued from preceding page

munications were wrecked, and "it makes one realize how fortunate we are that actual warfare has not visited our home shores. It is bad enough that our men and women are sacrificing their all—even their lives—for a good cause. At least our loved ones are comparatively safe and our homes intact —and I assure you that is a great consolation."

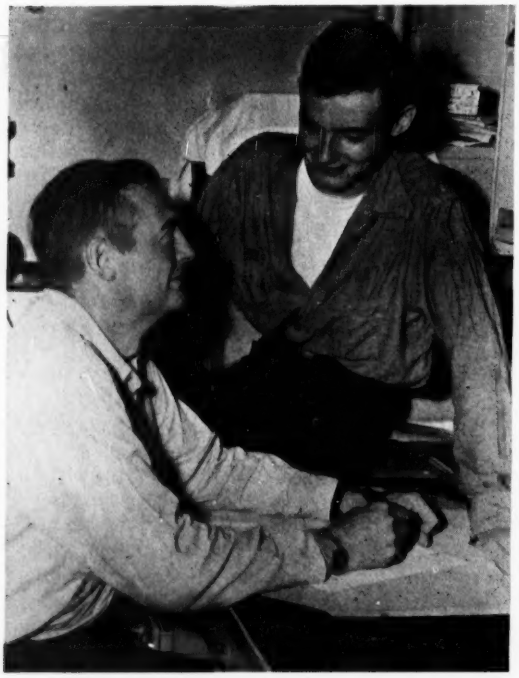
RE-UNION OFF MINDORO

One of the best stories, certainly from a local viewpoint, to come from the Pacific war zone is that of our *Commander William Davis,* former officer of the Providence Medical Association, and his son, Neal.

Sailing from the West coast about the same time, both father and son enjoyed a brief re-union off Leyte prior to the start of the invasion of Mindoro last December.

Commander Davis, medical officer in charge aboard an LST, was in the first line of advance on the Jap-held island.

In the ensuing invasion Japanese planes attacked the LST on which Commander Davis was the medical officer in charge, and scored a hit. The Commander and other members of the crew were trapped on the fantail of the craft as explosions cut off all escape forward. Swiftly administering morphine and caring for casualties, Commander Davis and another surgeon, who were to establish a hospital ashore once a beachhead had been established, worked at their task until the heat of the deck plates became unbearable and the men had to go over the side.



COMDR. WILLIAM P. DAVIS, MC, USNR, and son NEAL, confer after invasion of Mindoro in which both participated.

Picked up by a destroyer escort and taken ashore with other survivors, Commander Davis discovered that his son Neal, a hospital apprentice first class, was with the invading convoy. The following day, attired in an assortment of ill-fitting clothes, for he had lost all his personal effects when the LST went down, Commander Davis again had a happy re-union with his son and, according to his own account, negotiated a $5 loan from him which in itself is quite an experience for any father.

Subsequently Commander Davis was taken to New Guinea and thence flown back to the mainland. He is now re-assigned to the medical department at Quonset.

WITH THE AIRPORT BUILDERS

The laurels for the air victories over the Continent by the Allied fliers is one of teamwork, and every returning airman is quick to pay tribute to the entire personnel of the air corps for its work in providing the field strips and maintaining planes and airports to make possible the mass raids. Hence it is interesting to hear from *Captain John J. Donahue,* who has been overseas two years as a Surgeon with an aviation engineer outfit whose mission is to build and to maintain airports.

Captain Donahue was in England for a year where his group built one of the largest air bases there. Then came the move to France where several temporary airstrips for fighter planes were set up before a permanent base was established. Commenting on the local medical care Doctor Donahue writes that "around us now there are no French doctors. About seventy miles away is a large French city but the doctors there get very little gas for their cars and so refuse to come out. Consequently our French practice gets a bit busy at times and our high school French gets a workout. No fee, but occasionally some eggs, a relief from the powdered variety."

CORRESPONDENCE

NAVY DEPARTMENT
OFFICE OF
NAVAL OFFICER PROCUREMENT, BOSTON
150 CAUSEWAY STREET, BOSTON 14, MASS.

Dr. William P. Buffum, Secretary
Rhode Island Medical Society
Providence, Rhode Island
122 Waterman Street

Dear Dr. Buffum:

This letter is addressed to the Secretaries of the various District Medical Societies with the request that it be read at the next regular meeting.

The procurement of physicians for the Army has been suspended, but the need for NAVAL medical officers continues to be a number one priority. Recently a Washington representative of the Office of Naval Officer Procurement stated to the writer that the demand for physicians far outstrips all other phases of officer procurement and that doctors are desperately needed NOW! The nation-wide figure necessary to bring our medical forces up to the maximum level of efficiency is about 3000!

The reason for our request for physicians is obvious as we read the daily casualty reports, and the desire to help our wounded men should inspire every qualified doctor to serve in a direct military capacity. However, this office believes in making its appeal for physicians to organized medical groups rather than to individuals. We know that in many communities throughout the State and Nation a disproportion of medical personnel exists. In some instances, a given community may be far below its requirements, but in others, the number of practicing physicians exceeds the demands of the area. Therefore, it is earnestly requested that EVERY physician give conscientious thought to the medical needs of his community, and in so doing, we hope many will seek a commission at once.

Since the start of the war physical requirements have been modified. Physicians may now be accepted up to the age of 60—those in the older age groups being assigned to Naval hospitals, Dispensaries, and other Naval activities ashore. Physical defects which are *organic* constitute a cause for rejection. Waivers can be granted, however, for defects which were formerly disqualifying, such as variations in height and weight, defective vision, and others.

Interested physicians, without making any definite commitments, will be interviewed at their convenience at this office on any week-day. This will enable us to furnish additional information and to discuss each individual's problem. Again, let me emphasize — the need is great — the time is NOW!

Very truly yours,

H. S. GLIDDEN
Commander, MC, USNR
Senior Medical Officer

DISTRICT SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The 50th Annual Meeting of the Pawtucket Medical Association was held in the Nurses' Auditorium of the Memorial Hospital on Thursday, March 15, 1945 at 12 noon. The following members were present: Drs. A. Bertini, E. Cormier, J. Doll, W. Dufresne, P. Durkin, C. Farrell, G. Fox, F. Hanley, H. Hanley, J. Healey, R. Henry, W. Kalcounos, H. Kechijian, N. Kechijian, E. Kelly, J. Kenney, S. Kenney, T. Krolicki, E. Mara, M. Marks, O. Masse, J. McGinn, J. O'Brien, M. Rohr, J. Sheridan, J. Sullivan, A. Tetreault, E. Trainor, J. Turner, H. Umstead, and J. Wheaton.

The following Associate Members were present: Drs. K. Barr, E. Benjamin, M. Chapian, A. Eddy, H. Moor, and P. Harrington.

Guests present were: Dr. Morin, Dr. Sheridan, Mr. Blair, Dr. McVay, Dr. Helgerson, Dr. Tyler, and Dr. Markarian.

The following honored guests were present: Mr. Wright, Superintendent of Memorial Hospital; Mr. Harrington, Assistant Superintendent of Memorial Hospital, Dr. W. P. Buffum, Secretary of the Rhode Island Medical Society; Dr. A. A. Albert, President of the Pawtucket Dental Association, and Mr. Leo Clark, President of the Spatula Club.

After luncheon President Trainor called the meeting to order. The reading of the minutes of the previous meeting, as well as supplemental reports was omitted. The report of the Treasurer was read, accepted and placed on file.

Dr. Trainor presented the President's annual address in which he reviewed events of the past year and thanked all members who participated in these events. He urged greater attendance in the forthcoming meetings.

The election of officers and committees for the ensuing year was then held. Dr. Wheaton reported for the Nominating Committee (Drs. Wheaton, Kelly, and Trainor). The following slate was presented:

President	William N. Kalcounos, M.D.
Vice Pres.	James F. Sullivan, M.D.
Treasurer	Laurence A. Senseman, M.D.
Secretary	Mary-Elaine J. Rohr, M.D.

Standing Committee

Earl F. Kelly	1941-1946
G. Raymond Fox	1942-1947
Joseph H. Doll	1943-1948
Armand A. Bertini	1944-1949
Edward H. Trainor	1945-1950

Delegates

J. Lincoln Turner
Stanley Sprague
Walter Dufresne
Earl J. Mara

It was moved that the Secretary cast one ballot for the above slate. Further nominations were closed and the Secretary cast one ballot in favor of the entire slate.

President-elect William N. Kalcounos expressed his appreciation on being elected President and appointed the committees: The Permanent Ethics Committee: Drs. Wheaton, Kenney, Kelly and Fox; Publicity Committee: Drs. Doll, C. Farrell and Trainor; By-Law Revision Committee: Drs. Sprague, Henry, and Wheaton.

Dr. Kalcounos appointed Dr. Frank Hanley to arrange for an observance of the Fiftieth Anniversary of the founding of the Pawtucket Medical

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WILLIAM N. KALCOUNOS, M.D.
President, Pawtucket Medical Association
1945-46

DISTRICT SOCIETY MEETINGS

continued from page 285

Association and a tentative date of June 6 was agreed upon for a full day program including a golf tournament at the Pawtucket Golf Club and a banquet in the evening with a guest speaker.

The Secretary read a card of thanks from Mrs. Bernard L. Towle in appreciation for expression of sympathy on the recent death of Dr. Towle.

The Secretary read an application for associate membership from Dr. Thomas P. Sheridan.

The Secretary then presented a change in the By-Laws which has been approved by the Standing Committee, as follows: Section I, reading "This Association shall convene on the third Thursday of each month at such hour and place as designated by the President" shall be changed to "This Association shall convene *on or after* the third Thursday of each month at such hour and place as designated by the President".

The Secretary then read a communication from the Naval Officer Procurement Office asking for further voluntary enlistments. The age limit has now been increased to 60 years, these men being assigned to Naval Hospitals, Dispensaries and other Naval activities ashore.

The Secretary then read a communication from the Providence Medical Association regarding the smoke and dust problem which will be discussed at the April meeting of that Association and asking that the Pawtucket Medical Association send representatives to this meeting.

It was moved that the annual dues remain the same as last year namely $5.00. The motion was seconded and passed.

Dr. Trainor then presented Dr. John F. Kenney, President-Elect of the Rhode Island Medical Society, who acted as toastmaster. Dr. Kenney called upon Mr. Wright who responded in behalf of the Memorial Hospital. Mr. Harrington was then presented and acknowledged his thanks to the members of the staff for their cooperation during the past year. Dr. Kenney then called upon Dr. Buffum, Secretary of the Rhode Island Medical Society, who brought greetings from the Rhode Island Medical Society and spoke about the coming Annual Meeting and the high calibre of the men who will take part in the programs. Dr. Kenney then presented Dr. A. A. Albert, President of the Pawtucket Dental Association who extended the greetings of his society. Mr. Leo Clark, President of the Spatula Club spoke about the cooperation between the doctors and druggists and expressed the thanks of the Spatula Club for this cooperation.

Dr. Kenney then turned the meeting over to Dr. Edward C. Morin who introduced Mr. Edward Dooley who gave an interesting and entertaining talk. The meeting adjourned at 1:30 P. M.

WILLIAM N. KALCOUNOS, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, March 5, 1945. The meeting was called to order by President B. Earl Clarke at 8:30 p. m.

The President announced that in view of the fact that the minutes of the previous meeting are to be published in the RHODE ISLAND MEDICAL JOURNAL the reading of them would be omitted unless there was a request.

The Secretary reported for the Executive Committee as follows:

At its recent meeting the Executive Committee took the following action:

1. It approved of the proposed plans of the Smoke Abatement Committee of the Association as outlined by the President, and it authorized the President to conduct a meeting for the purpose of organizing a permanent Citizens' Committee and to draw from the Treasurer of the Association sufficient funds to pay the expenses involved for this meeting.

2. It approved of the Association sharing with the State Medical Society in the expenses incurred in connection with the mid-winter meeting held on February 5, 1945.

3. It empowered the President to appoint a War Veterans' Committee to carry out the proposals made by Dr. Jackvony in his Presidential address to the Association on January 8, and it also instructed the Secretary to advance the same proposition to the House of Delegates of the State Medical Society for the creation of a similar committee by that Society.

4. It moved to place a marker on the flag standard to acknowledge the gift of the flag and standard made by Dr. Jackvony, and placed in the Library auditorium.

5. It moved to notify the hospitals of the district of the names of four members dropped for non-payment of their dues.

6. It moved to accept and place on file the 1944 financial report of the Medical Milk Commission of the Association.

The motion was made to accept and approve the report of the Executive Committee. The motion was seconded and passed.

The President announced that he appointed Dr. Walter Weigner as the Association's representative on the Providence Veterans' Retraining and Re-employment Committee. He also reported that he had appointed the new Smoke Abatement Committee to consist of Dr. Edward Cameron as Chairman, Dr. Alex. M. Burgess, and Dr. Anthony Corvese. The President called for a report from Dr. Cameron regarding the activities of his Committee. Dr. Cameron reported as follows:

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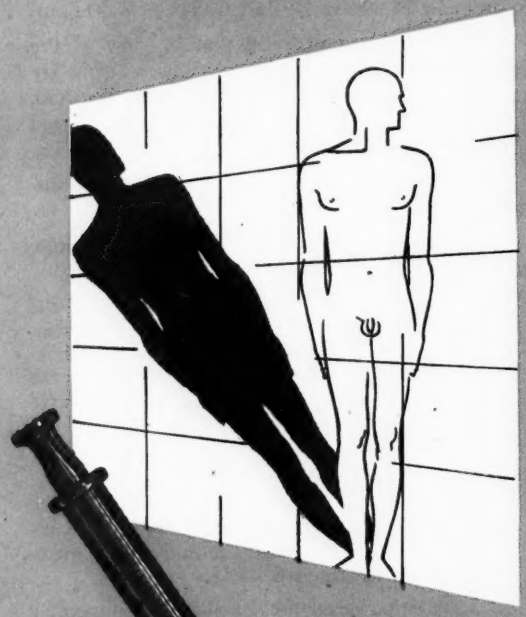
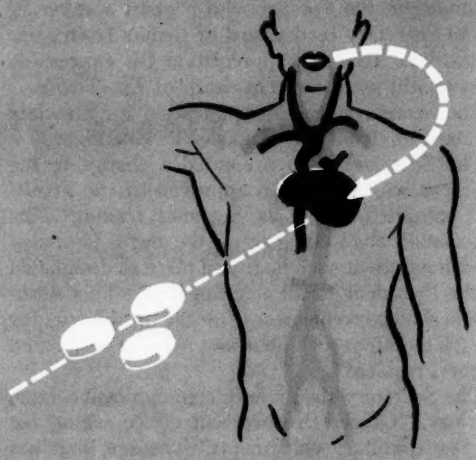
COMBINED ANDROGENIC THERAPY

(PER ORAL AND PARENTERAL)





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DISTRICT SOCIETY MEETINGS

continued from page 287

"Under the spark plugging of our President, Dr. Clarke, Ex officio member of this Committee, and the valued aid of our Executive Secretary, Mr. John Farrell, this committee is able to report progress. We have held several meetings at which a review of the literature relating to this subject has been discussed.

"At a meeting held February 24, 1945, Mr. Mancini, Engineer for the City of Providence, was present and gave a very interesting talk relating to the efforts toward the Smoke Control Nuisance in this City since 1928. We are looking forward to much help from Mr. Mancini in the future.

"Mayor Roberts has been interviewed regarding the Smoke Abatement Problem and his spirit of cooperation is much appreciated. A number of contacts by committee members with Civic Representatives have found cordial response and helpful attitudes.

"On February 27, 1945, Commander Bloomfield of the Public Health Service, the guest of Dr. Deery of the State Health Department, met with the Committee and outlined the manner in which Federal investigations had been carried on, and gave worthwhile suggestions.

"It is planned to arrange a dinner meeting this month to which a number of Civic Group Representatives will be present, and at that time, a committee at large will be formed. It was felt that this meeting should be held and the committe formed before the April Providence Medical Association meeting, when Prof. Mills of the University of Cincinnati will give his paper on the Medical Aspects of Air Pollution. It is the hope of the Committee to form a permanent organization to carry on this work."

The Secretary reported that at its recent meeting the Executive Committee moved to recommend for election to active membership the following:

JOSEPH A. HINDLE, M.D.
MATTHEW W. ROSSI, M.D.
GUSTAF SWEET, M.D.
KATHARINE PARDEE, M.D.

Dr. Jesse E. Mowry moved the unanimous election of these candidates to membership in the Association. The motion was seconded and passed.

The President introduced Dr. Frank Fulton who presented a report of a case on "Coarctation of the Aorta".

Dr. Fulton had reported two cases thirteen years ago before the Providence Association; one with autopsy findings. The second patient died in January of this year of a cerebral accident. An autopsy was obtained which showed the usual findings and some other variations, in the order that the large vessels branched from the aorta. The stenosed lumen in this case was only 3 mm. in diameter. Some pictures of the material were presented which showed the usual very large internal mamary ar-

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DISTRICT SOCIETY MEETINGS

continued from preceding page

teries, etc. The patient, incidentally, had a horseshoe kidney. The history of this patient showed that she had the usual high blood pressure. When Dr. Fulton first saw her in 1931, it was about 250/90. At that time, she became decompensated and had to spend five weeks in the hospital. This decompensation was repeated in 1943, she had to stop work. Dr. Fulton stated that usually these patients show enough typical diagnostic signs on careful examination to permit an accurate diagnosis. X-rays show notching of the ribs due to the dilated vessels.

The President introduced Dr. Sidney Farber of Boston who discussed "Pancreatic Insufficiency and the Coeliac Syndrome".

Dr. Farber stated that Dr. Samuel Gee of London wrote a classical description of coeliac disease early in the 19th century. He listed the chief symtoms of the syndrome and stated that they were variable and not all found in any one case. The coeliac syndrome can follow various etiologic factors. It occurs as an idiopathic condition probably identical to non-tropical sprue, in chronic parenteral infections such as chronic mastoiditis, in connection with congenital malformation of the heart and G. U. tract and particularly of the bowel as in Hirshsprung's disease and in pancreatic insufficiency. The differentiation of cases as to the underlying etiologic factor is very important. In examination for pancreatic deficiency, determination of the trypsin contect of the duodenal juice is the most important procedure. The very interesting paper of Dr. Farber was discussed by Drs. Utter, Bell, Cook and Adelman.

The meeting adjourned at 10:30 p. m.

Collation was served.

FRANK W. DIMMITT, M.D., *Secretary*

HOUSE OF DELEGATES

In accordance with the regulations of the By Laws of the Society the House of Delegates will meet in May. The session is called for WEDNESDAY, May 9, to be held at the Medical Library at 8 p. m. A complete report of matters under discussion will be sent to each delegate prior to the meeting, and members of the House are urged to discuss local and state problems with their respective district societies, and then be prepared to participate in all the deliberations of the House on May 9.

ACRYLICS IN GENERAL DENTISTRY

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surface inlays, failures due to cement have been unknown. One jacket which recently fractured after three year's service had the cement still adhering to the jacket walls. Three things may be responsible for success in cementing acrylic restorations: —

1. At least two opposing walls of the preparation must be parallel to an extent not possible with former porcelain work. The paralleling of these walls has instituted a mechanical type of retention in addition to that of the cement. Tapered preparations are responsible for many cement failures. No case has ever been placed where cement alone was used for retention.
2. Tin foil matrices have never been used. The roughness due to separators has no doubt added to cement adherence.
3. All preparations have been made with the thought in mind of presenting an adequate bulk of material in the restoration. This has allowed the use of sound, routine oxyphosphate of zinc crown and bridge cement without shadowing through. This cement, mixed to a sticky but not thick consistency, has been adequate. All restorations have been cemented on by seating with a horned mallet and orange-wood stick.

The appearance of processed soft plastics has altered somewhat our conception of denture prosthesis. Heretofore our concepts and techniques have been based on the assumption that we must cover a soft, yielding and not insensitive mucosa with a hard denture base. This new concept of an intermediate layer of soft, yielding material as part of the deture base and as a bearing surface next to the soft mucosa, gives rise to much discussion. At present the materials for this use are offered on the basis that the profession shall use them discriminately and with caution. Some of the earlier materials disintegrated quite rapidly. The newer materials give promise of a longer age life and stability. Certainly they can be used at the present time in all immediate insertion cases and in those cases where soreness and dissatisfaction are prevalent. From these cases we will be able to judge whether an extreme use of this type of material is indicated on all full and partial dentures. The use of this material is somewhat the same as routine denture powder and liquid. Dr. Stanley Tylman has presented their techniques and uses in the Dental Digest, May 1944. The technique involves the displacement of the ridge area during test packing of the denture. This displaced area is then filled with the mixed soft acrylic. Test packing and processing continues as usual. Some failures of this material may be attributed to the fact that low heat processing has not been sufficient to thoroughly process the soft acrylic. It is emphasized that one hour boiling should follow any low heat processing technique for the complete processing of soft acrylic materials. Many cases where soreness and discomfort have been the rule have made entirely comfortable and satisfactory by the use of a soft denture lining. New cases may be made with the soft lining, or existing cases may be relined.

For the past few years much interest has centered on self-curing reline materials. Most of these have involved a simple polymer dissolved in a solvent. While many are so-called permanent, it is doubtful if any deserve such an adjective. These relines serve a temporary purpose only and as such are highly valuable in our practices. But do not be disappointed when they have served their useful life. There is no substitute for a fully processed case. Many of these relines are accompanied by quite a burning sensation. Even though it is doubtful if actual burning occurs or that serious results will follows, it is hereby cautioned that should once a person be found with an allergy to this monomer, the consequences may be extremely serious.*

Direct acrylic fillings have been mentioned in the literature and have been researched for a number of years. At present their status is somewhat obscure. Many successful fillings have been placed. They have been successful from the standpoint of esthetics and retention. However, it remains that with present materials there is a contraction during mouth polymerization which causes a loosening of most of these fillings. Many do not come out but are loose enough to admit moisture. Others which are apparently firm are such simply because contraction has tightened the fillings in their complex cavity preparation. Among these are Class V incisal corners, which seem to be working out exceptionally well. At the present time, all of these fillings must be regarded as experimental and cannot be termed successful until at least six months has passed with no loosening. At the present time, a monomer has been developed and is being researched which apparently has the ability to cause a mouth polymerization-expansion. It is too soon to determine whether these filling are satisfactory or not.

Thus we have acrylics. Prosthetics, crown and bridge, perhaps even operative dentistry will succumb to the plastic spell. A prediction might well be that soon plastics will serve as a basis for all dental restorations.

THROUGH . . .  *the Microscope*

THE sickness rate among 200,000 male industrial workers was 70% higher during the third quarter of 1944 than in the like 1938 period, according to the chief statistician for the United States Public Health Service . . . . . the increase is attributed to greater employment of both young and old workers, the hiring of workers long unemployed, of inexperienced workers, those physically handicapped and rejected by the armed services . . . . . also workers are more frequently subject to emotional strains and plants are overcrowded . . . . .

Meanwhile we still wait for a real evaluation by experts of the State Cash Sickness Compensation program in Rhode Island where about 90% of the population is covered. Much has been written, but there appears to be little effort to attempt a thorough actuarial study of the whole program and a readjustment accordingly.

WHAT PRICE CARELESSNESS?

The total of awards in death cases resulting from the Hartford circus disaster on last July 6 reached $1,136,475.85 by March 15 when the board of arbitration filed 28 new awards amounting to $232,900. All but one of the 132 death claims have now been heard . . . there were 168 deaths in the fire but not all have been scheduled for the arbitration and in a few cases no legal action of any kind has been taken . . . . . Six officials and employees of the circus company have been given jail terms on the ground they were negligent in staging the circus, although one of the officials wasn't in Hartford the day of the fire . . . . . Meanwhile the report of the State fire marshal has been made public stating the fire was caused by carelessly thrown burning cigarette ends . . . . . so the really guilty in this great tragedy escape punishment!

THE MIRACLE OF AIR TRANSPORT

May be properly given the evacuation story of the war casualties by the Air Transport Command which has brought home one out of every five wounded Americans returning to this country in 1944, according to an OWI report . . . . . Air evacuation of the sick, wounded and injured, which became a military necessity early in 1942, today is ranked as one of the five greatest life-saving measures of military medicine . . . . . It is the "method of choice" in the prompt removal of the wounded from battle zones in all parts of the world . . . . . Approximately 800,000 patients of the American and Allied forces have been transported by the AAF in all theaters of operation in the past two and a half years.

The story becomes the more dramatic as we consider how much greater might have been the American battle deaths which the Metropolitan Life Insurance Company, through its statistical bureau, reports "in 1944 were the largest for any year in the entire history of this country." In estimating a total of 145,000 deaths the report states "our losses last year were about five times those of 1943 and over three times as many as in the 25-month period from Pearl Harbor to the end of 1943."

FIGHTING WITH THE FIELD ARMY

The American Cancer Society, with its great organization of voluntary workers under the banner of the Field Army which carries forward the educational and social welfare phases of a national cancer control program, opened a five million dollar campaign this month aimed at providing funds for cancer research. With millions contributed yearly for various health projects it is amazing to find that the American people have never yet contributed as much as one million dollars a year to fight a disease that kills 60% more people than die from all contagious and infectious diseases together.

With Eric Johnston, president of the U. S. Chamber of Commerce, as its national chairman, and with outstanding leaders in every State — Edward L. Coman in Rhode Island — the movement should gain the strength necessary to produce funds to probe every research study advisable.

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THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

CHARLES L. FARRELL, M.D.

The Author. *Charles L. Farrell, M.D., of Pawtucket, R. I. Member, Board of Directors, Association of American Physicians and Surgeons.*

THE Association of American Physicians and Surgeons is a new organization of American physicians founded on sound legal basis to give its members a positive guarantee of protection from political regimentation and organized to take effective action in Medical Economics, Legislation and Public Relations. This Association was incorporated, not for profit, by the Lake County Medical Society with temporary headquarters at Gary, Indiana.

Last August the first Annual Meeting of the Association was held in the Hotel Stevens in Chicago at which time the President, Officers and new Board of Directors were elected. A statement of the Association's eight objectives is as follows: 1. To organize all ethical physicians and surgeons of the United States and its possessions in an Association so established that its members may determine and enforce the conditions under which they will or will not give their services. 2. To prevent participation by a minority of its members in any plan or scheme for the distribution of medical care that is deemed by the majority to be inimical to the interests of the Association and not conducive to the improvement of the public health and welfare. 3. To establish by means of a national Assembly of its members, in which all members have both voice and vote, a truly democratic organization of physicians and surgeons that is governed by its members and therefore actually representative of them. 4. Through effective action in the public interest, and under the direction of a qualified public relations counsel, to earn the good public relations and resulting public approval and support the profession so richly deserves. 5. To move from the defensive to the offensive in the work toward the actual solution of problems in medical economics and to keep the economics of medicine under the management and control of the practitioners of medicine. 6. By means of adequate organization and competent executive action, to translate into successful accomplishment the decisions of the profession which have heretofore remained only words on the record. 7. To establish a Washington office of the Association for the execution of prompt and effective legislative action by the profession. 8. To provide a medium of expression for and actual assistance to members of the profession in the armed forces, during both the time of their military service and the period of their readjustment to civil practice.

This organization is governed by an assembly of its members patterned after that of the American Bar Association which may be overruled only by a referendum of the entire membership of the A. A. P. S., and will for the first time give American medicine a voice and vote in the national policy, selection of officers and representatives, and the management of the national affairs of organized medicine.

No individual or clique can ever gain or hold control of this Association against the wishes of its members. Government by its members and actually representative of them as against government and representation by a few is one of the cardinal purposes of the Association of American Physicians and Surgeons. The charter provides "There shall be an annual meeting of the members of the Association to be known as the Assembly which all members in good standing may attend and in which they may have a voice and vote."

The by-laws further provide that any member may present a resolution in the Assembly. Officers of the organization are elected not by the House of Delegates but by the Assembly which assures the Association that its leadership faithfully and accurately will represent the membership or by prompt democratic processes easily and promptly can be censured and removed.

Any member of the Association of American Physicians and Surgeons may attend its meetings, may be heard, and may have his ideas democratically accepted or rejected by a majority of his own colleagues. In discussing the relationship with the National Physicians' Committee, Dr. J. S. Niblick, a past president of the Lake County Indiana Society, states the N. P. C. collects money from physicians and others for a propaganda campaign against the Wagner-Murray Bill and similar legislation. Thus it appears to be wholly negative in its purpose, and is without representation or authority from the physicians of America to do

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ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

continued from preceding page

anything positive and constructive. "None of the eight immediate objectives of this Association can now or ever be achieved by the National Physicians Committee," Dr. Niblick asserts. This new Association is not intended to interfere in any way with the Scientific and educational work of the American Medical Association, which has made, and must continue to make, magnificent contributions to science and medicine.

But it has been demonstrated that the American Medical Association can do little more in the important work of legislation, public relations and medical economics than to make studies and recommendations.

Another organization is needed and needed now if we are to successfully combat such legislation as the medical and health provisions of the Wagner-Murray-Dingell Bill which is not expected to be enacted into law in its entirety but modifications of which will certainly become law if we are not organized to correct the failures and inadequacies of organized medicine that have placed us in our present unenviable position. If we are intelligently and strongly organized as free American citizens we can refuse in the public interests to participate in any scheme for the distribution of our services that would depreciate their quality.

Up to this point the A. A. P. S. withheld intensive organization work to preserve the resources of the organization pending results of the November election. There recently has been a growing and well-founded conviction that socialized medicine or some form of radical medical change is in the not too distant future. Unless the American physicians are organized to resist the intrusion of an unwelcome would-be employer such as the state or federal bureau, it will most certainly be a reality. "Time for Public Education has passed". We must now arm ourselves in haste to resist the impending destruction of our freedom. Every report from Washington indicates that health insurance legislation will be a major issue of the 79th Congress.

The United Public Health League in one of its letters quotes a Washington newspaper as saying that "The most explosive single piece of domestic legislation before the 79th Congress will be the Wagner-Murray-Dingell Bill." This Bill is an administration "MUST". Another quotes Senators Wagner and Murray and Representative Dingell as determined they will reintroduce their Bill and state that "Daily in the Congressional Record there have been demands for committee hearings." The American Association of Physicians and Surgeons has recently mailed to every physician in the United States material for study and examination. The officers and members of this Associ-

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ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

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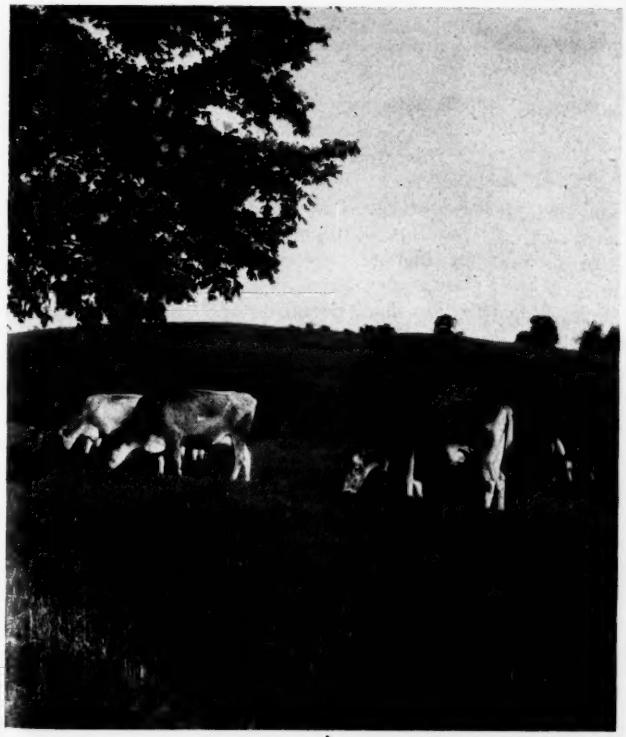
ation are willing to address medical society groups, small or large, throughout the country. Formal approval of the A. A. P. S. has been voted by many county medical societies, by the House of Delegates of the Colorado State Medical Society and in no instance has there been disapproval by any society before which the Association has been fully discussed and properly represented.

If the Association can interest sufficient members before legislations such as the Wagner-Murray-Dingell Bill is passed, the medical profession will then remain free to achieve other positive and vital objectives of the Association, free to continue its scientific organizations. The statement of objectives is necessarily brief and merely designed to bring to the attention of the members of the Rhode Island Medical Society the existence and objectives of this Association. Further details and information can be had by addressing Dr. Charles L. Farrell, 166 Pawtucket Avenue, Pawtucket, Rhode Island. Application blanks and further information will be furnished upon request.

Incidently, membership in the American Medical Association is a prerequisite to membership in the A. A. P. S.



H-836

AN ACT
PROVIDING FOR THE INCORPORATION OF NON-PROFIT MEDICAL SERVICE CORPORATIONS AND DEFINING THEIR POWERS

(Introduced in the House of Representatives, Rhode Island General Assembly, on Tuesday, March 13, 1945. Referred to the Committee on Corporations.)

SECTION 1. As used in this act:

(a) "Non-profit medical service corporation" means any corporation organized pursuant hereto for the purpose of establishing, maintaining and operating a non-profit medical service plan.

(b) "Non-profit medical service plan" means a plan whereby specified medical service is provided to subscribers to the plan by a non-profit medical service corporation.

(c) "Medical service" means such professional services rendered by persons duly licensed under the laws of this state to practice medicine or surgery, and appliances, drugs, medicines, supplies and nursing care necessary in connection with such services, or such expense indemnity for such services, appliances, drugs, medicines, supplies and care as may be specified in any non-profit medical service plan. Medical service shall not be construed to include hospital services.

(d) "Subscribers" shall mean those persons or groups of persons who shall contract with a non-profit medical service corporation for medical service pursuant to a non-profit medical service plan.

SEC. 2. (a) Each non-profit medical service corporation shall be incorporated as a charitable corporation under the provisions of article III of chapter 116 of the general laws, 1938, and shall be subject thereto and to this act. The laws of this state relative to insurance companies or to the business of insurance, and acts in amendment thereof or in addition thereto shall not apply to any non-profit medical service corporation unless expressly so provided therein.

(b) A majority of the directors of each such non-profit medical service corporation, other than a corporation organized pursuant to the provisions of chapter 719 of the public laws, 1939, must at all times be doctors of medicine duly licensed to practice under the laws of this state.

(c) No articles of association of a non-profit medical service corporation shall be filed in the office of the secretary of state unless and until the governor of this state shall have certified in writing upon such articles that he has determined that public convenience and advantage will be promoted by the establishment of such corporation and that the filing of such articles has the approval of the Rhode Island Medical Society as evidenced by an affidavit of the president and secretary of such society.

SEC. 3. (a) Each non-profit medical service corporation may contract with its subscribers for such medical service as may be from time to time provided under any non-profit medical service plan adopted by such corporation.

(b) The rates charged by such non-profit medical service corporation to its subscribers shall be consistent with the proper conduct of its business and the interests of the public and shall at all times be subject to the approval of the director of business regulation.

(c) Nothing contained in this act or in any non-profit medical service plan shall affect the ordinary professional relationship between the person rendering medical services under such plan and the subscriber to whom such services are rendered; and no action based upon or arising out of such relationship or relating to medical services rendered pursuant to a non-profit medical service plan shall be maintained against the non-profit medical service corporation operating such plan.

SEC. 4. Every such non-profit medical service corporation shall annually, on or before the first day of March in each year, file in the office of the director of business regulation a statement, verified by at least two of the principal officers of said corporation, of its condition on the 31st day of December then next preceding, which statement shall contain such matters as the director of business regulation shall prescribe and shall be available for inspection by the public.

SEC. 5. It shall be the duty of the director of business regulation at such time or times as he may see fit but at least once a year to make an examination of the financial condition and methods of doing business of every non-profit medical service corporation. Each such corporation so examined shall pay for such examination at the rate of ten dollars a day for each examiner reasonably employed in making such examination, provided that no such corporation shall be required to pay for such examinations during any one year a total sum in excess of two hundred dollars.

SEC. 6. No person shall be engaged to solicit subscribers to any non-profit medical service plan upon a commission basis or upon any other basis

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ENABLING ACT FOR MEDICAL SERVICE CORPORATION

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whereby the payment of the compensation or expenses of such person shall be conditioned upon the enrollment of subscribers unless the method of solicitation and rate of compensation shall have had the prior written approval of the director of business regulation.

SEC. 7. The funds of any non-profit medical service corporation shall be invested only in the manner permitted by the laws of this state for the investment of assets of savings banks of this state.

SEC. 8. Every non-profit medical service corporation is hereby declared to be and shall be deemed to be a charitable corporation and an incorporated public charitable institution.

SEC. 9. Any non-profit hospital service corporation organized pursuant to the provisions of chapter 719 of the public laws, 1939, may, with the consent of the Rhode Island Medical Society evidenced by the affidavit of the president and secretary of such society filed in the office of the secretary of state, amend its articles of association to adopt the provisions of this act and thereupon such corporation shall have and exercise all of the powers and be subject to all of the duties and responsibilities of a non-profit medical service corporation to the same extent as though it had been incorporated as a non-profit medical service corporation.

SEC. 10. This act shall take effect upon its passage.

MONEY FOR RESEARCH

Speaking before the sub-committee on Wartime health of the Senate, Dr. Henry S. Simms, of Columbia University College of Physicians and Surgeons, reported that diseases of the heart and arteries killed more than five hundred and thirty-six thousand persons in 1940, but only $93,835 was spent that year on research on these diseases. By contrast, $2.18 research money was spent for each of the 164,906 cancer deaths, $4 for each death from infectious disease, other than infantile paralysis, and $525 from each of the 1,026 infantile paralysis deaths or $100 for each case dead or seriously crippled.

The Secretary of the Rhode Island State Dental Society announces the election of the following doctors to active membership:

Dr. Albert J. Puerini, "D" south Dental Dispensary, U.S.N.T.C., Sampson, New York

Dr. Morris Sweet, 290 Westminster Street, Providence, Rhode Island

Dr. Edward J. Wasilewski, 21 Huldah Street, Providence 9, Rhode Island

MILITARY ANNOUNCEMENTS

TRANSFERS

MAJOR MICHAEL ARCIERO, MC, APO 412, c/o Postmaster, New York, N. Y.

LT. COL. CLARENCE E. BIRD, MC, 317th General Hospital, Fort Lewis, Washington

LT. CHARLES E. BRYAN, MC, Station Hospital, McChord Field, Tacoma, Washington

CAPT. ALPHONSE R. CARDI, MC, 0435434, APO 29, c/o Postmaster, New York, N. Y.

LT. COMDR. JARVIS CASE, MC, USNR, c/o Fleet Post Office, San Francisco, California

CAPT. E. ARTHUR CATULLO, MC, 0513870, APO 230, c/o Postmaster, New York, N. Y.

CAPT. GEORGE F. CONDE, MC, APO 218, c/o Postmaster, New York, N. Y.

MAJOR J. A. DAILEY, MC, 0324751, APO 689, c/o Postmaster, New York, N. Y.

CAPT. JOHN J. DONAHUE, MC, 0504034, APO 216, c/o Postmaster, New York, N. Y.

LT. JOHN J. DONNELLY, MC, 0312131, 259th Engr. Com. Bn., Camp Bowie, Brownwood, Texas

CAPT. STEPHEN J. FORTUNATO, MC, APO 68, c/o Postmaster, New York, N. Y.

CAPT. I. GERSHMAN, MC, APO 230, c/o Postmaster, New York, N. Y.

CAPT. JOHN H. GORDON, MC, APO 627, c/o Postmaster, New York, N. Y.

LT. COL. JAMES P. HEALEY, MC, APO 448, c/o Postmaster, New York, N. Y.

LT. HUBERT HOLDSWORTH, MC, APO 218, c/o Postmaster, New York, N. Y.

CAPT. RODRIGO D. C. REGO, MC, APO 339, c/o Postmaster, New York, N. Y.

MAJOR RALPH D. RICHARDSON, MC, 0-1696223, APO 589, c/o Postmaster, New York, N. Y.

LT. COMDR. NATHANIEL D. ROBINSON, MC, USNR, Med. Dept., U.S.M.C.A.S., Santa Barbara, California

LT. A. K. SCHOENBUCHER, MC, APO 652, c/o Postmaster, New York, N. Y.

MAJOR E. B. SINCLAIR, MC, 0-333082, APO 3, c/o Postmaster, New York, N. Y.

COMDR. WILLIAM A. STOOPS, MC, USNR, c/o Postmaster, San Francisco, California

CAPT. FRANCIS E. TEMPLE, MC, Lovell General Hospital North, Ward 115, Fort Devens, Mass.

MAJOR JACOB WARREN, MC, APO 565 Unit 2, c/o Postmaster, San Francisco, California

PROMOTIONS

LT. ALPHONSE R. CARDI to Captain
MAJOR A. H. CLAGETT, MC, to Lieutenant Colonel
LT. HARRY E. DARRAH to Captain
CAPT. DUNCAN FERGUSON to Major
LT. STEPHEN J. FORTUNATO to Captain
LT. ALBERT J. GAUDET to Captain
LT. THOMAS J. LALOR, MC, to Captain
LT. GUSTAVO A. MOTTO to Captain
LT. EDWARD L. SMITH to Lt. Comdr.
MAJOR ERIC P. STONE, MC, to Lieutenant Colonel

NOT CANCELED

The art contest sponsored by Mead Johnson & Company on the subject of "Courage and Devotion Beyond the Call of Duty" (on the part of physicians) has *not* been canceled or postponed.

The closing date remains May 27th, 1946.

PRELIMINARY REPORT OF HEALTH DEPARTMENT STATISTICS

PROVIDENCE — RHODE ISLAND

1944

	1944	1943	1942
VITAL STATISTICS			
Deaths all	3,268	3,575	3,115
Deaths under 1	275	354	312
Deaths over 70	1,241	1,219	1,058
Births	8,192	8,564	8,273
Marriages	2,619	2,707	2,890
Infant Mortality	33.57	41.34	37.00
Death Rate	12.42	13.69	12.03
Birth Rate	31.14	32.81	31.55
PRINCIPAL CAUSES			
1. Heart Disease	1,057	1,101	979
2. Cancer	451	493	426
3. Pneumonia	174	186	147
4. Nephritis	198	235	204
5. Cerebral Hemorrhage	247	231	234
6. Auto Accidents	28	31	38
LABORATORY EXAMINATIONS			
Chas. V. Chapin Hospital	27,113	32,846	35,827
MILK DEPARTMENT			
No. Samples Tested	23,621	20,252	23,816
No. Licenses Issued	1,411	1,429	1,712
PHYSICIANS			
No. of Visits to Sick Poor	2,266	4,160	7,046

	1944	1943	1942
DIPHTHERIA IMMUNIZATION			
No. Schick Tests	7,900	7,391	7,385
No. Alum Toxoid Treat.	4,199	4,006	4,106
SMALLPOX IMMUNIZATION			
No. Vaccinated	2,871	2,434	2,294
INSPECTORS:			
Food Inspector:			
Inspections	8,133	8,221	5,649
Licenses Renewed	1,650	1,482	1,856
New Licenses	100	42	92
Transfers	103	61	99
Licenses Withdrawn	0	0	7
Licenses Not Approved	2	0	9
Licenses Revoked	3	3	0
Sanitary Division:			
No. of Visits	6,855	6,451	5,111
Dog, Cat Bites—Visits	1,270	1,318	1,344
Kennel Lic. Approved	80	65	44
Garbage Lic. Approved	20	20	23
NURSING VISITS			
Communicable Diseases	7,114	10,246	13,193
Child Hygiene	25,169	26,161	26,432
Parochial Schools	5,010	4,060	4,514
Tuberculosis — Home (DNA)	4,845	5,964	4,252
CHILD HEALTH STATIONS			
Visits by Children	3,293	3,945	6,789

COMMUNICABLE DISEASES	CASES 1944 Res.	CASES 1944 Non Res.	CASES 1943 Res.	CASES 1943 Non Res.	DEATHS 1944 Res.	DEATHS 1944 Non Res.	DEATHS 1943 Res.	DEATHS 1943 Non Res.
Diphtheria	15	7	13	9	2	1	1	2
Scarlet Fever	263	86	355	57	1	1	2	0
Measles	3038	36	1641	13	1	1	1	0
Whooping Cough	388	6	1344	29	2	1	2	5
Pulmonary Tuberculosis	383		459		58	14	57	11
Septic Sore Throat	6	0	15	0	0	0	0	0
Streptococcus Sore Throat	61	2	72	2	1	0	0	1
Gastro Enteritis	58	28	72	34	19	13	39	21
Bacillary Dysentery	21	6	2	10	0	0	0	0
Poliomyelitis	6	8	80	103	0	2	3	3
Epidemic Meningitis	54	60	181	206	5	6	23	18
Typhoid Fever	5	3	5	3	1	0	0	0
Paratyphoid Fever	2	4	2	1	0	1	0	0
Epidemic Encephalitis	1	2	1	2	0	0	1	1
Ophthalmia Neonatorum	0	0	1	0	0	0	0	0
Undulant Fever	0	2	1	1	0	0	0	0
Tetanus	2	3	2	2	0	0	1	0
Trichinosis	0	2	1	1	0	0	0	0
Tularemia	0	0	1	0	0	0	0	0

Includes Non-Residents

MICHAEL J. NESTOR, M. D.
Superintendent of Health

THROUGH THE MICROSCOPE

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DRAFTING THE NURSES

With the nurse draft bill claiming national attention the question of nurse power for hospitals and physicians is receiving no little attention throughout the States. As a partial solution to the problem of securing enough nurses for the military forces, and at the same time keeping the home front protected, the Council of the Academy of Medicine in Cincinnati voted to recommend to all hospital superintendents that they establish a plan of group nursing in the hospitals whereby one private duty nurse will take care of at least two more patients who are located near each other, and also that a regulation be adopted whereby no patient may have a private duty nurse except in cases where the patient is critically ill, and then only for as long as the critical period exists . . . . . determination of the status of critically ill would rest with the physician in charge of the case and with the supervisor of nurses.

RADIO INTERFERENCE

For several years the medical profession has been accused by various radio interests of interfering with radio communications, specifically as regards police, Coast Guard, television, FM, and other services. As a result, the Federal Communications Commission has been conducting hearings regarding its proposal for new allocations of frequencies. Since such changes would affect the use of presently operated diathermy apparatus there has been no little propaganda disseminated regarding the action. The Council on Physical Medicine of the AMA, as represented by its secretary at the FCC hearing in Washington on March 2, voted that "it (the Council) feels in the interest of public relation it is desirous of supporting the stand of the FCC and it does not care to be in opposition to the federal agency which is responsible for this important decision."

The conclusion of the Council was reached after due consideration that the FCC has made careful study and examination of the problems involving medical service and public relations as they relate to the use of diathermy in the practice of medicine. The Council also voted that the suggestion to confine diathermy to one single frequency was unwise, and at least three frequency channels might well be allocated. It also voted that the FCC publish a statement announcing the time limit the physicians may be allowed to use their uncontrolled diathermy apparatus before asked to screen them, discard them or substitute frequency controlled apparatus, and a time limit of not less than 5 years was suggested for physicians to liquidate their investment.

HEALTH ON THE HOME FRONT

Despite the strains of 3 years of wartime living and working, and an increasing shortage of phy-

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THROUGH THE MICROSCOPE

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sicians, nurses, and hospital facilities, the physical and mental health of America's civilians shows no indication of a serious decline, according to an OWI report based on data furnished by the USPHS, the Procurement & Assignment Service, the Bureau of the Census, and the War and Navy departments.

The shortage of doctors engaged in civilian practice is growing more critical. Of the 100,000 physicians estimated in the U. S., one-fifth are doing important research jobs in experimental laboratories, in disease prevention, in sanitation control and in war vital administrative jobs. Some are too old to give more than part time service to the medical profession.

However, the figure of 80,000 remaining is misleading, according to officials. Before the war one third of our physicians were between the ages of 45 and 64. Today one half of them are in this group. Each physician is not only sharing the load formerly carried by men in the service; he is also handling increased civilian demand for medical services caused by war strains, crowded living conditions, etc. Proof of the increased demand is that the average hospital load today is 20% greater than it was in 1940.

If the medical needs of the next decade are to be met adequately it would appear that there should be Congressional support of Senator A. J. Ellender's (of Louisiana) bill (S 637) which includes provisions for the deferment of adequate numbers of premedical students and further provides for the deferment of medical students as will be sufficient to supplement civilian sources of students for the maintenance of full classes at the medical colleges. This bill would carry out the recommendations of the House of Delegates of the AMA made last year.

VARIED SERVICE OF DENTAL OFFICERS

In addition to making more than a million and a half men available for military service, dental officers are rendering other notable service to the Army. In a recent speech before the University of Southern California Dental Alumni Association, Lieutenant Colonel John C. Brauer, DC, Chief of the Dental Standards Branch, Office of the Surgeon General, called attention to "the dental officers on the maxillofacial teams; the dental officers on the neurosurgical teams, who are called upon to fabricate tantalum plates to restore cranial defects caused by injury; and the dental officers who developed the acrylic eye and who are now routinely processing and fitting such prostheses."

COMPONENT SOCIETIES BY MEDICAL DISTRICTS

Society	*Delegates*	*Councillor*	*Officers*	*Meeting Date*
Kent County Medical Society	Rocco Abbate	Rocco Abbate	President, E. A. Kostyla Vice Pres., L. H. Duquette Secretary, B. F. Tefft Treasurer, John A. Mack	2nd Thursday of each month
Newport County Medical Society	James Callahan Samuel Adelson	Norman MacLeod	President, C. S. Dotterer Vice Pres., W. A. Stoops 2nd V. Pres., A. M. Tartaglino Secretary, P. P. Ciarla Treasurer, N. U. Zielinski	4th Tuesday of every other month — Jan., Mar., May, July, Sept. and Nov.
Pawtucket Medical Association	Joseph L. Turner Walter J. Dufresne Earl J. Mara Stanley Sprague	James L. Wheaton	President, Wm. N. Kalcounos Vice Pres., J. F. Sullivan Secretary, M. E. J. Rohr Treasurer, L. A. Senseman	On or after 3rd Thurs. of each month at time and place designated by the Pres. (Except July-Aug.)
Washington County Medical Society	Julianna R. Tatum	John P. Jones	Pres., F. A. Kenyon Vice Pres., S. P. Turco 2nd Vice Pres., L. Morrone Sec'y and Treas., J. R. Tatum	
Woonsocket Medical Society	Victor H. Monti	Guyon G. Dupre	President, H. L. Emidy Vice Pres., J. W. Reilly Secretary, P. E. Boucher Treasurer, R. H. Dowling	2nd Tuesday, alternate months Sept. - June.
Providence Medical Association	Emery M. Porter Henry E. Utter Alex M. Burgess George W. Davis Antonio D'Angelo K. K. Gregory Edward Famiglietti Peter F. Harrington Charles Southey Frank I. Matteo E. Wade Bishop G. Edward Crane	Emery M. Porter H. P. B. Jordan Arthur E. Martin G. W. Waterman Gordon McCurdy A. V. Migliaccio	President. B. E. Clarke Vice Pres., P. C. Cook Secretary, F. W. Dimmitt Treasurer, H. E. Harris *Providence Delegates* Robert H. Whitmarsh Frank W. Dimmitt E. S. Cameron A. Henry Fox Harold G. Calder Joseph L. Belliotti Louis A. Sage Bertram H. Buxton Arcadie Giura	1st Monday of each month Oct.-May incl.

RHODE ISLAND MEDICAL SOCIETY

Society	*Officers*	*Annual Meeting*	*Chairman, Elected Committees*
Rhode Island Medical Society	President, E. S. Wing Vice Pres., F. G. Taggart Pres. Elect, J. F. Kenney Secretary, W. P. Buffum Treasurer, J. E. Mowry Ass't Sec'y, A. L. Potter Ass't Treas., C. J. Ashworth	May 16 & 17, 1945 at Rhode Island Medical Society Library, 106 Francis Street, Providence 3, R. I.	Wm. H. Foley, Committee on Public Laws H. G. Calder, Committee on Publication J. P. Eddy, 3rd, Com. on Med. Education H. C. Pitts, Committee on Med. Economics C. L. Farrell, Com. on Industrial Health E. F. Burke, Committee on Arrangements H. C. Partridge, Committee on Library Russell Hunt and Philip Batchelder, Auditors

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